Report on the death of a woman at HMP and YOI New Hall in February 2005

Report by the Prisons and Probation Ombudsman for England and Wales

March 2006

This is the report of an investigation into the death of a woman at HMP New Hall on 2 February 2005. She was awaiting trial at Leeds Crown Court, and had been in prison for nearly three months when she died. The purpose of the investigation was to establish the circumstances and events surrounding her death, including the quality of care provided by the Prison Service.

The investigation was undertaken by two investigators from my office. I commissioned a clinical review from West Wakefield Primary Care Trust. I thank West Yorkshire Police for their assistance to my investigators.

I would also like to express my thanks to the Governor of New Hall and her staff for the help and active co-operation that my investigators received throughout the investigation.

A key part of the investigation was to ensure that the woman's parents and family had the opportunity to raise any concerns they had about her death. My Family Liaison Officer and investigation colleagues met the woman's parents, and have done their utmost to answer their questions. I offer my profound condolences to them for their loss.

I took over responsibility for investigating deaths in prison custody in April 2004. This is the fourth apparently self-inflicted death that I have investigated at New Hall since then. The woman harmed herself on many occasions before her death. Her background of self-harming behaviour and significant mental health issues is an obvious link between her and some of the other investigations I have already carried out. I refer in the report to some excellent practice at New Hall, including an impressively detailed, speedy and caring response to her death. However, I also highlight apparent major professional shortcomings in the immediate response when she was first discovered hanging in her cell in the Healthcare Centre.

This version of my report, published on my website, has been amended to remove the names of the woman who died, her family, my staff and any prison staff or prisoners who were involved in my investigation.

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

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SUMMARY

1. The woman was born in 1978. She was 26 years old when she died in cell H2-8 in the Healthcare Centre at New Hall on the evening of 2 February 2005. She was well known at the prison, as she had served a number of previous sentences there.

2. On this occasion, she was received at New Hall on 9 November 2004. She had been remanded in custody charged with making threats to kill. She remained continuously in custody at New Hall until her death. She made a number of court appearances, and on 11 January was committed to Crown Court for trial. Her next court appearance was due to take place on 9 February.

3. The woman was held in the Segregation Unit (CSU), at her own request under Prison Rule 45, from the day of her arrival until 21 January. As soon as she arrived at the prison, the suicide and self harming monitoring arrangements involving the F2052SH form were initiated as she told the nurse who interviewed her that she had attempted to kill herself outside prison.

4. The woman's prison records show many incidents of self harm during her previous sentences, and also during the last three months of her life at New Hall. Her segregation and self harm at risk status were reviewed at appropriate intervals. She was interviewed by a psychiatrist who worked at New Hall on a sessional basis, and also by a psychiatrist instructed by her defence solicitors.

5. For several weeks in December and January, there was concern that she was not eating. On 21 January, a Nurse located her in the prison's HCC for further observations, noting that she had deteriorated after not eating for several days. The woman told a chaplaincy volunteer, and regular visitor to her, that she heard voices saying she was a "fat pig", and so had stopped eating. The woman said she believed that when she stopped eating, the voices diminished.

6. On 30 January, another Nurse found the woman lying on her bed with a ligature around her neck. Staff entered her cell, and removed the ligature. She was then transferred to cell H2-8 which had camera surveillance.

7. On the day of her death, the woman was seen by a large number of staff at New Hall. She had lengthy sessions with the chaplaincy volunteer, and with her probation officer. She asked the probation officer to talk to her solicitor about the progress of the court case, and also to make contact with the National Self Harm Association. The woman attended education classes, and a case review of her F2052SH status took place at 2:30pm. Staff attending the review were encouraged that she seemed to be settling well in the Healthcare Centre, but decided she should continue to be observed at 30 minute intervals and the F2052SH should remain open. The woman expressed an interest in attending the gym.

8. She was locked in her cell at 4:50pm, after sharing tea with other prisoners in the in-patient unit. No recorded observations took place until 6:15pm, when she was found hanging from a sink tap in the toilet area of her cell. A male nurse was working in the upper healthcare that evening, and he was on the scene almost instantly. When she was first discovered, there were three members of staff (a nurse and two prison officers) on duty in the upper healthcare centre. Telephone evidence indicates that the male nurse spoke to a female nurse at 6:23pm. He asked her for advice about the action he should take but, as he spoke calmly, the female nurse did not think the situation was grave. She finished dispensing medication to prisoners on the ground floor of the healthcare centre, and at approximately 6:30pm went upstairs to see if the male nurse needed any help. No cardio pulmonary resuscitation (CPR) was commenced before her arrival, no additional staff had been summoned and the emergency bag had not been obtained from the Nurses' Office. The female nurse has 25 years professional experience, and her assessment was that the woman had already died or was near death when she first saw her.

9. Telephone records show that a prison officer telephoned the prison's Control Room at 6:30pm to request that an ambulance be summoned. West Yorkshire Ambulance records indicate they were called to the prison at 6:35pm. The Control Room log records the call to the Ambulance Service as taking place at 6:36pm. Although New Hall is located some distance from the nearest town, the paramedics arrived rapidly but pronounced the woman's life extinct at 6:56 pm.

10. I have made recommendations in relation to the male nurse to the Wakefield West Primary Care Trust and to the Prison Service's Area Manager for Yorkshire and Humberside. I recommend further investigation as to why he did not sign the F2052SH between 4:50 and 6:15pm. I am also greatly concerned by the long delay before any assistance, either internal or external, was summoned. The evidence I have seen suggests that he did not appreciate the gravity of the situation, and did not take all appropriate steps to try to resuscitate the woman. I recommend further investigation by the relevant authorities of his apparent failure to exercise his professional duty of care to her.

11. The arrangements for breaking the news of the woman's death to her mother were prompt and effective.

12. The report concludes with 12 recommendations while drawing attention to the very good practice demonstrated in the aftermath of the sad events documented in this report.

CONDUCT OF THE INVESTIGATION

13. This investigation was conducted by two investigators from my office. Their first visit to New Hall was made on 4 February 2005, two days after the woman's death.

14. Notices were issued to staff and prisoners telling them of the investigation and its terms of reference, and offering them the opportunity to participate.

15. My investigators examined the cell in the Healthcare Centre where the woman died. They also visited the CSU where she was located on both this and previous occasions at New Hall.

16. My investigators obtained a very large amount of documentation relating to the woman's last and previous periods of imprisonment. Interviews were conducted with one prisoner and a wide range of staff who had significant contacts with her, especially on the last day of her life.

17. One of my Family Liaison Officers arranged a meeting with the woman's mother. My investigation has attempted to answer the questions posed by the mother and her friends at that meeting. The mother engaged a solicitor in Leeds who has made contact with my investigators on a number of occasions. The documents requested by the solicitor have been supplied, and further questions posed by the solicitor on the mother's behalf have been addressed.

18. I am very grateful for the assistance my investigators received from the detective sergeant who led the investigation into the woman's death for West Yorkshire Police. My investigators have also had access to the reports written following the apparently self-inflicted deaths of prisoners at New Hall in April, July and October 2004.

19. An independent clinical review of the medical care the woman received whilst in prison has been conducted by a reviewer appointed by Wakefield West Primary Care Trust. The reviewer worked to terms of reference agreed with my investigators.

20. My investigator discussed a number of current national policy issues with the Deputy Head of the Women's Team at Prison Service headquarters. I am also very grateful to the Healthcare Consultant and Programme Director for the Women's Team and Juvenile Group, for supplying a background note on three significant matters:
    - A review commissioned by Home Office Minister Baroness Scotland which will examine provision for women with complex needs in the criminal justice system
    - Criminogenic factors of women offenders
    - Information about a range of projects being taken forward by the Women's Team

BACKGROUND

21. There is a great deal of documentary information about the woman contained in her previous prison records. Another important source of information is the pre-sentence report written by her probation officer in February 2001. The report was written for a Magistrates' Court, and at the time the woman was charged with offences of threats to kill, possession of an offensive weapon and making nuisance telephone calls.

22. The woman was born in 1978 and suffered from a congenital deformity of the hip, which resulted in a limp. Her condition affected her ability to walk and stand for long periods, and she was still receiving treatment when the probation officer wrote her report. The woman remembered being bullied at school as a result of her limp.

23. At the age of 17, she left home in order to acquire some independence. She lived in student accommodation and attended a nursery nursing course but did not complete the course. At the time of the report, she was unable to work because of problems with her mobility.

24. The woman told her probation officer that she drank 40 units of alcohol a week, and also regularly used cannabis. In 1999, she received an Absolute Discharge at a Magistrates' Court for possession of cannabis resin.

25. The report stated that she had a history of self-harm. In 1999, she was transferred from hospital in London to hospital in her local area after sitting on the parapet of Tower Bridge and talking to a security guard about the number of people who committed suicide there.

26. In the Offence Analysis Section of the report, the probation officer explained that the current alleged offences were directed at police officers, and were part of an ongoing pattern of behaviour involving similar offences and incidents for which the woman had previous convictions dating back to 1999. The woman told her probation officer that she realised there was an obsessive-compulsive nature in her behaviour towards the police in her local area.

27. In paragraph 26 of the pre-sentence report, the probation officer wrote that over a lengthy period of time the woman had become obsessive in her behaviour, which was mainly directed at the police. At times, her behaviour could be interpreted as being of nuisance value, such as frequent silent phone calls. However, the length of her obsession and the escalation of her behaviour, together with the specific and serious threats to one officer, gave her probation officer concerns about future risk.

28. In 2001, the woman was sentenced to four years imprisonment for two separate threats to kill in January 2001, and for possession of an offensive weapon (a knife) in a public place in late January 2001.

29. In February 2001 a specialist registrar in forensic psychiatry wrote a psychiatric report for her court appearance. In the section of the report dealing with her

previous psychiatric history, he said that the woman first presented to psychiatric services in November 1996 when she was 18 years old. She was admitted to hospital as an informal patient after a referral from a college counsellor. She had complained of hearing voices for about four months prior to her admission. She was not observed to display any hallucinations or other symptoms of mental illness during the five day admission, and she was discharged without any psychotropic medication.

30. In October 1997, the woman's General Practitioner (GP) referred her again, and she attended an outpatient clinic in October 1997. She again complained of hearing voices, this being a female voice asking her to do "silly things". She was referred again by her GP in July 1998 after experiencing low moods, irritability, bouts of aggression and thoughts of taking an overdose. She failed to attend two outpatient appointments and was subsequently discharged back to the care of her GP.

31. The woman was readmitted to hospital in December 1998, after taking an overdose of 32 paracetamol tablets. On assessment, she did not display any symptoms of mental illness, but was admitted overnight as part of a crisis intervention package. At her own request, she was discharged the following day.

32. She was readmitted to a local hospital in May 1999 after spending the previous evening in a psychiatric ward at a London Hospital. The specialist registrar recorded that the woman's friend had called the police, as she had spoken about jumping off Tower Bridge. She spent five days in hospital, but was not considered to be depressed or to have any suicidal ideas. She was eventually discharged, after coming back drunk after an access visit.

33. There was a further two-day assessment in November 1999 after the woman attended the same hospital with suicidal ideas. In October 2000, she was referred by her GP, and went to the psychiatric outpatients clinic. At the time, she admitted drinking approximately 50 units of alcohol per week and was attending a local alcohol counselling service.

34. The woman was assessed by the Duty Psychiatric Senior House Officer in December 2000, after two overdoses during the previous weeks. On both occasions, the overdose was said to be impulsive and to occur after drinking alcohol. During the interview, she threatened to kill a policeman, and said that he had previously sexually assaulted her. It was thought that hospital admission was not required, as she did not display any evidence of a depressive or psychotic illness.

35. The specialist registrar visited the woman at New Hall in February 2001, in order to write his court report. In the Opinion section at the conclusion of his report, he wrote:
"[The woman] has had long standing contact with the psychiatric services characterised by her self presentation at times of crisis, typically when threatening to or having committed self-harm. During a number of inpatient assessments she has not displayed any aversive symptoms of a major mental

illness and has been consistently diagnosed as suffering from a personality disorder."

36. A Consultant Forensic Psychiatrist interviewed the woman in the Healthcare Centre on 20 April. He had been asked to write a confidential psychiatric report for the Crown Court. She told him that she had had enough of life, and had tried to kill herself on eight occasions in the preceding 14 days. She said that she refused food, lacerated herself and tied ligatures as a means of killing herself. She particularly wished to be free of the stresses of prison life, and to be free of flashbacks. Physically,she felt weak and tired, and her mood was low all the time with little variation. She said all these symptoms had been present for a long time, but were markedly worse since an alleged sexual assault by a policeman in September 2000.

37. The Consultant Forensic Psychiatrist's report referred to times in the woman's life when her level of alcohol intake increased dramatically, and remained out of control. She told the psychiatrist that she regularly used cannabis from the age of 21, and continued to do so until being remanded into custody. His conclusion was that she was not suffering from any significant form of mental illness. In particular she was not suffering from a psychotic disorder or a significant form of depression. His report said that:
"The most appropriate psychiatric diagnosis in this case is of personality disorder of the emotionally unstable borderline type … Her personality disorder, combined with her seriously irresponsible behaviour, would merit a legal classification of psychopathic disorder. However, in my opinion, this disorder is not amenable to compulsory treatment in hospital under the terms of The Mental Health Act 1983. [The woman] also suffers from dependent alcohol abuse which has no doubt exacerbated the abnormalities in her personality and compounded her offending behaviour."

PREVIOUS OFFENCES AND CUSTODIAL HISTORY

38. Her first appearance in court was in June 1999, when she was convicted of sending a letter or other article conveying an indecent or grossly offensive message. On 17 December of the same year, she was sentenced to four months imprisonment for a number of offences, including sending letters or other articles conveying a threat. In March 2000, she was sentenced to 14 weeks imprisonment for using the public telecom system to send false phone messages to cause annoyance, inconvenience or needless anxiety. Five months later, she was sentenced to a further eight weeks imprisonment for persistently using the public telecommunication system to cause annoyance, inconvenience or needless anxiety. The sentence on 6 September 2001 of four years imprisonment has already been described. In March 2003 and July 2004, she was sentenced to further short periods of imprisonment for common assault and affray respectively.

39. The woman was well known at New Hall as she served all or some of each sentence there. She also served parts of the four year sentence at HMP Low Newton, HMP Durham and HMP Buckley Hall.

PREVIOUS SELF HARMING BEHAVIOUR IN PRISON CUSTODY

40. There are numerous instances when the woman engaged in self-harming behaviour while she was in prison custody. During 2001, for example, Report of Injury to Inmate forms (F213) were completed at regular intervals at both New Hall and Low Newton. On 1 April, she was found with a ligature tied securely around her neck. Later the same day, she was found with a further ligature around her neck. On 2 April, a prison officer checked her in her room in the CSU. The officer got no response and went into the room to find her semi conscious with a ligature made from shoe laces tied tightly around her neck. Her face was blue. The ligature was removed and a nurse was called immediately.

41. On 30 June, the woman was found again in the CSU with a ligature around her neck. When the ligature was removed, her throat was bruised and raw. Staff recorded that her throat was swollen and her eyes were puffed. On 10 July, she was found again in the CSU with a ligature around her neck. A similar event occurred on 14 August. The ligature was quite tight and she had slight bruising around her neck. The next day a ligature was again removed from her neck.

42. On 17 August, an officer discovered that the woman had covered the observation panel of the cell door, so that staff could not see into her cell. She would not respond to staff, so they went into the cell and found another ligature round her neck. The following evening, the same thing happened. The same officer wrote that the woman had obstructed the panel, and did not respond to staff. She had tied a ligature round her neck, and it was removed.

43. Four days later, the officer recorded that the woman had blocked the panel and the officer could not obtain a response. She opened the hole for the fire hose, and saw that the woman's face was a reddish purple colour. Assistance was quickly summoned, and a ligature was removed from her neck. The nurse recorded that the woman had swelling to her eyes and reddening to her face, but her pulse was regular and strong. The same officer had to respond in the same way two nights later. She again opened the fire hose hole and saw that the woman was a purple colour. The Night Orderly Officer (NOO) and nurse were sent for. They responded very quickly and the ligature was removed. On 26 August, another officer again recorded that the woman's cell was entered so that a ligature could be removed from her neck.

44. The woman was sentenced to four years imprisonment on 6 September, and was transferred to Low Newton. Two days later on 8 September, there were two reports of injuries. Just after midnight, an officer reported that she had cut her left arm using a piece of glass from a watch face. The following evening, it was discovered that she had cut the same arm with a piece of glass she had secreted on her person. Her arm was cleaned and dressed and the glass was removed.

45. During the four year sentence, the woman was seen by a number of psychiatrists. On 12 September 2001, a Consultant Forensic Psychiatrist at

the hospital she had attended before, wrote to the Medical Officer at Low Newton. He recorded that the woman was being constantly observed and wanted to be "off them" - that is, off the constant observations. She accepted that her past behaviour had caused concern. His letter continued:
"She is still determined to kill herself, saying that she had had enough of being a prisoner and didn't care any more ... Essentially, she does not impress as being mentally ill … She is definitely at serious suicidal risk, and will attempt this if given any opportunity whatsoever. She must therefore continue on twenty-four hour observations, and I suspect that these will be necessary for the foreseeable future."

46. On 29 November, the woman made a more serious suicide attempt. She was found with a noose around her neck, cyanosed, not breathing and without a pulse. (Cyanosis is a bluish-purple discoloration of the skin, usually resulting from a deficiency of oxygen in the blood.) The Medical Record stated that approximately five minutes went by before there was any spontaneous breathing (gasping in first instance). She was taken to hospital, and returned to the prison on 7 December. The psychiatrist who saw her on Christmas Eve, was concerned that she might have sustained some degree of brain damage following her suicide attempt.

47. On 23 August 2002, the same psychiatrist wrote to the Medical Officer at Low Newton and said that the woman had refused food and been on hunger strike for the previous four weeks. The letter continued:
"Although she is not eating any food, she is drinking fluids, milk etc. [The woman] is also considered to be an ongoing suicide risk. She openly states that she will kill herself if given the chance. I understand that her last attempted suicide was five days ago, when she tied a ligature around her neck whilst hiding herself under her bed sheets. She is on constant observation."

48. His conclusion was that she was not presenting with any type or form of mental illness, and he saw the primary diagnosis as borderline personality disorder with a long history of deliberate self-harm.

49. A locum Consultant Forensic Psychiatrist assessed the woman at Buckley Hall on 11 November 2002 and wrote to the Medical Officer. He said she told him that she previously harmed herself as a mechanism for relieving tension rather than with the intention to commit suicide. He recorded that:
"However, she said that the last episode made her extremely fearful on account of her unconsciousness and narrow escape. She assured me that she had no further intentions to self-harm provided that she remained in her current location."

50. The woman had been in the CSU at Buckley Hall for the previous four months. The psychiatrist expressed concern that her suicidal behaviour had been responded to by transferring her to the CSU, though he recognised the difficulty of managing her at a prison which had no inpatient facilities.

CHRONOLOGY OF EVENTS AT NEW HALL BETWEEN 9 NOVEMBER 2004 AND 2 FEBRUARY 2005

51. The woman's last period of imprisonment at New Hall began on 9 November 2004. She was remanded in custody, accused of making threats to kill. She arrived at the prison late in the morning, and the First Reception Healthscreen was conducted by the male nurse who was first on scene when she died. She told the male nurse that she was last at the prison five months earlier, and that she suffered from asthma. When he asked whether she had been treated for any form of mental health problems, she replied that her GP had treated her for depression in 2001. She said she had received medication for her nerves, and that trazodone and chlorpromazine were prescribed in 2001. When asked whether she had tried to harm herself, she replied that she had attempted to kill herself by inhaling gas and added that she currently felt suicidal.

52. The male nurse referred her to the Medical Officer and to the Registered Mental Nurse (RMN) Screening Clinic. He assessed her as fit for normal work and location. He also decided to open a F2052SH (Self-harm at Risk Form) immediately. This form can be opened by any member of staff who is concerned about a prisoner. Its purpose is to ensure that as much help as possible is given to a prisoner during a difficult period when she may either be at risk of self-harm, or after a self-harm incident. The form was opened at 12:30pm, and the nurse recorded his concerns about the woman's history of self-harm and that her manner was agitated. He said that she was determined to kill herself and presented as at significant risk of self harm. He noted that she would be located in a single cell in the CSU. The first entry on the Daily Supervision and Support Record Section of the F2052SH was at 1:00pm. It states that, whilst being interviewed, the woman said she would kill herself, that she had nothing to live for and was fed up with her way of life.

53. She was taken to the CSU just before 2:00pm, and just after 3:00pm, she told an officer that she had taken 20 tablets. The prison's Medical Officer (MO), decided that she should be sent to the Accident and Emergency (A and E) Department at a hospital in Wakefield. The MO wrote to the doctor in charge at the hospital to inform him of the woman's statement that she had taken 20 dihydrocodeine tablets at approximately 3:00pm. The woman was drowsy and sleepy, but was able to communicate. The A and E Senior House Officer assessed her and wrote to the MO. He said that she denied taking an overdose, and that she had suicidal thoughts but "states not going to do it now. Has a plan". She returned to her cell in the CSU just after 9:00pm.

54. Between 9 November 2004 and 21 January 2005, the woman remained continuously in the CSU. She then agreed to move to the prison's Healthcare Centre. During the last three months of her life, there were many incidents of self-harm. These are discussed in greater detail later in this report.

55. The woman made a written request on 9 November 2004 to be located in the CSU for her own protection. Prison Rule 45 authorises a prison governor to segregate a prisoner, at his or her request. Reviews of her status were held at regular intervals, as required by Prison Service Order 1700. The F2052SH

also remained open throughout the period at New Hall until her death, and again regular reviews of the risk of self-harm were carried out.

56. The woman twice appeared before the Governor for alleged breaches of prison rules. The first adjudication was when she refused to move to cell 2 in the CSU on 2 December 2004 after being told to do so. At the adjudication on 4 December, the acting Deputy Governor punished her by ordering seven days forfeiture of the privilege of canteen, but the punishment was suspended for two months. On 31 January 2005, two days before her death, she appeared in front of another governor and admitted calling an officer "a fat bastard". On this occasion, the punishment was a caution about her behaviour.

57. The first adjudication, when she refused to move to another cell, followed staff concern about her welfare. At the time she was located in Cell 3 in the CSU, but she had blocked the cell observation panel and restricted staff visibility into the cell. A Use of Force form completed at the time states that she was required to move to cell 2, which allowed better observation, as she was on the F2052SH. The woman refused to walk to the new cell and, according to the form, became aggressive and lunged towards staff. Approved Control and Restraint Techniques were used by staff, in order to relocate her to the safer cell. The entire relocation was witnessed by the Chairman of the prison's Independent Monitoring Board (IMB). (The IMB is an independent committee of local citizens, appointed by the Home Secretary, whose role is to ensure that prisoners are treated correctly and in accordance with the rules.)

58. During her time at New Hall, the woman had extensive dealings with the Head of Safer Custody (HSC) at the prison. The HSC's responsibilities include oversight of the CSU, as well as the challenging task of dealing with self-harm issues in an environment where self-harm is relatively commonplace. The HSC met the woman frequently in relation to her Rule 45 reviews. She wrote him a very important letter on 22 December 2004 in which she raised the issues of:
    i medication
    ii psychiatric care
    iii recreation, education and employment
    iv room occupancy.

    She also wrote a formal complaint about the HSC on 10 January 2005, but the matter did not come to the attention of the Prison Service's Yorkshire Area Manager until after her death. The HSC also received a letter from the woman's solicitors on 19 January 2005, to which he responded on 25 January.

59. The woman did not receive many visitors, but she was in correspondence with a young woman who had herself previously been a prisoner at New Hall. On 24 December 2004, the Governor of New Hall wrote a memorandum to the Healthcare Manager at the prison, following up concerns expressed by this woman. The woman had written to another governor at New Hall, saying that: "I know you are not the Governor of the CSU (Segregation Unit) but I have got worries about one of the prisoners on there. [The woman] wrote to me today stating she had been tying ligatures and intends to hang herself if the voices demand so.

I am really worried about her mental state and I am wondering if you could influence Healthcare to get the psychiatrist to hurry up and see her before she does resort to hanging herself."

60. The Healthcare Manager noted in the woman's Medical Record that she had received the memo from the Governor. She noted that the woman had actually been seen by the consultant forensic psychiatrist the previous day. She recorded that the psychiatrist had decided to increase the woman's medication, and he himself wrote in the Medical Record on 23 December that she was well known to him previously. He referred to the court report he had prepared in May 2001.

61. The woman received good support from the Chaplaincy team at New Hall during the last three months of her life. A particularly noteworthy contribution was from a volunteer who visited the prison every Wednesday. The chaplaincy volunteer acted as the woman's champion, confidante and friend, and it was clear to my investigator that the two women liked and respected each other very much. In interview, the volunteer explained to my investigator that she would collect the woman from her cell to take her to the chapel where they had lengthy, private conversations in its peaceful and supportive atmosphere.

62. Shortly before the woman's death, the Chaplaincy had introduced a system of short written contributions for inclusion in F2052SH of women at risk of self-harm. The volunteer's entry for 12 January 2005 states that she spent one hour and 15 minutes with the woman. She observed:
"[The woman] was quite low in spirit today and is trying hard to be positive but not succeeding. She believes that her only way forward is to obtain the appropriate psychiatric care she needs."
They spent another hour together on 26 January, after the woman had been moved to the Healthcare Unit. She observed:
"[The woman] was much happier today – she is enjoying having daily education and mixing with small numbers of women."

SELF-HARM ISSUES PRIOR TO THE WOMAN'S DEATH

63. A significant number of self-harm incidents are recorded in the woman's F2052SH, Local Incident Report forms, and on Forms 213SH which are used to record any act of self-harm or attempted suicide. On 14 November 2004, staff entered her cell and removed a ligature from around her neck. Half an hour later, it was noted that she had blocked the observation panel and staff again had to enter the cell to remove the block. At 1:10pm on 17 November, staff entered her cell and removed a ligature.

64. On 23 November at 11:50am, the chaplaincy volunteer wrote in the F2052SH that the woman had told her that the voices in her head were making her self-harm and she had to kill herself but she did not want to. She wanted the voices to go away. At 8:30pm the same evening, she was discovered lying on the floor with a ligature tied. She did not respond to staff, and so they entered the cell and removed the ligature.

65. At 1:45pm on 16 December, staff entered the woman's cell to remove a ligature from her neck, and at 2:45pm on 29 December the same thing happened.

66. 9 January 2005 was a particularly disturbed day for the woman. At 8:40am, she showed an officer her right arm. She had made superficial burns with a cigarette which were dressed by a nurse. At 10:25am, staff entered the cell to offer her the opportunity to go to chapel. She jumped out of bed and lunged at one officer, then attempted to grab another around her head, knocking the officer's glasses across the floor. A general alarm bell was sounded and staff used approved control and restraint methods to restrain her. At 12:35pm, an officer recorded that a ligature was removed. It was anchored to a sink tap near the door, similar to the circumstances of her death the following month. At 3:50pm, the same afternoon, the woman told the Chaplain that she would hang herself. At 6:14pm she rang her cell bell and reported to staff that she had burned her left forearm with a cigarette.

67. On 21 January, the woman was moved from the CSU to the Healthcare Centre, then on 30 January at 2:25pm she was found with a ligature around her neck. The local incident report form completed by a nurse states that she was found lying on her bed with a ligature around her neck. Staff entered the cell and the ligature was removed. At the time, she was in Cell H2-3.

68. The next entry in the F2052SH at 2:50pm states that the woman was moved to a cell which had camera surveillance. The new cell was H2-8, where she remained until the time of her death. Pictures were fed from the camera room to a bank of television screens in the Nurses Office in the In-patient Area of the Healthcare Centre. However, no members of staff were assigned to watch the television screens and no tapes were retained by the prison. This meant that the cameras had no memory, and staff could only see what was happening at the moment that they looked at the screen.

69. At 10:45am on 1 February, a Chaplain recorded in the F2052SH:

“Had a chat with [the woman], she told me about her concerns of the ‘voices’ she is hearing and about how she feels about her weight. I advised her to speak to the nursing staff. She did mention that she would hang herself as staff couldn’t see her in the toilet.”

THE HEAD OF SAFER CUSTODY

70. As already indicated, the HSC was the prison's most senior member of staff whom the woman saw most regularly. She wrote a very clearly worded letter to him on 22 December 2004, which he noted and signed on 29 December. The first issue raised by her in her letter was her medication. She wrote that the medication prescribed by the prison doctor was not the same as that prescribed by her own psychiatrist. She felt that the dosage given by the prison doctor was not helping her, so she refused to take it. She said she had complained, but the doctor was not prepared to give her the dosage she was receiving before she came into prison. She asked for her medication to be reviewed.

71. There is indeed a record of a formal complaint by the woman, dated 12 November 2004, which relates to her medication. She complained that she would like to be on the dosage of trazodone that she had received whilst in the community. In response on 25 November, the MO wrote on the complaint form that she had been sent to hospital because she took an overdose of dyhydrocodeine. The MO wrote that, for safety purposes, the level of trazodone was reduced. He added that she was dependent on trazodone, and he thought that he would slowly reduce her dose.

72. In interview, the HSC said he had suggested that the woman write down her concerns, because she sometimes found it difficult to express them during the formal segregation review which could be attended by people whom she did not know well. He said that he did not pass her document to healthcare colleagues, but kept it on her CSU file "so that it could be discussed and monitored at seg reviews". Although the HSC referred to speaking to healthcare staff about her medication and discussing it in reviews of her segregation, there is no documented confirmation of this.

73. The second matter which the woman wrote to the HSC about was her psychiatric care. She wrote of a commitment in the F2052SH review "three weeks ago" that she would be put in regular contact with the RMN, but she claimed she had still not seen one. She added that the psychiatrist from a unit in Dewsbury had twice arranged to see her, but had cancelled both appointments. The last sentence of this section reads as follows:
"I am hearing voices and am sure that this, linked with my depression can be treated but if I never get to see anyone from this specialist area, how can I get the help that I need?"

74. The HSC said in interview that he had enquired why the appointments had been cancelled. He was not aware of any pending visits from a psychiatrist. He said that he seemed to recall discussing the contents of the woman's letter at a segregation review after he had been given it. He said that he asked healthcare staff at the reviews to ascertain whether the psychiatrist from Dewsbury would attend to conduct a psychiatric assessment. Later in the interview, the HSC calculated that the woman would have given him her letter after the segregation review on 29 December which she did not attend in

person. Again there is no record that the woman's comments about her psychiatric care were duly considered at the next segregation review.

75. The third issue raised by the woman was her need for something to occupy her time. She wrote that she had great difficulty mixing with other people, and told the HSC that she would appreciate it if he could sort out some work for her to do "without having to mix with other prisoners". He explained in interview that he had a long discussion with her about the difficulty of putting her on Prison Rule 45A whilst permitting her to mix with prisoners in the workshops. The woman was actually asking for some work that she could do inside her own CSU cell, but the HSC replied that he was not aware at that time of any sort of in-cell type of activity which she could undertake. He added that his strategy was to arrange as much out of cell activity time as possible.

76. The woman's last point was in relation to Room Occupancy, and she wrote that she had asked to move to a room round the corner. At the time she was in Cell S1-9, where she said she did not sleep because of hearing voices in her own head. She wanted to get away from the constant disturbances through the night from the other prisoners. She wrote that she knew the HSC wanted to put her on normal location, but argued that if she could mix with others successfully she would not be in the CSU now. He explained that she had actually been in one of the five rooms in the rear section of the CSU, but had been moved to one of the front cells so that it was easier for staff to observe her. The HSC added that he regularly challenged the woman's theory that she was at threat from other prisoners, and he spoke of introducing her to normal location in a gentle and staged way.

77. On 19 January 2005, the woman's solicitor wrote to the HSC expressing concern about her psychiatric condition, and reporting that she had written to him consistently confirming that she was hearing voices. He also suggested that she should not be removed from the CSU until a psychiatric opinion was obtained, because of her significant concerns about removal. By the time the HSC returned from annual leave, and replied to the letter on 25 January, the woman had been moved to Healthcare. He explained that the move was for a period of mental health assessment.

78. The Continuous Medical Records Section of the woman's Medical record contains a lengthy entry made by the staff nurse in Healthcare on 21 January. She writes that the woman was seen on the CSU where she was refusing to respond to wing staff. She had not eaten for several days, and was unable to produce a urine sample when asked by the nurse. The staff nurse asked for her to be moved to Healthcare for further observations as she had deteriorated. The nurse left the woman and returned after ten minutes to find that she had got dressed and was willing to relocate. She admitted that she needed further observations and complained of dizziness.

HMP NEW HALL

79. HMP/YOI New Hall is a local and training prison for adult women, female young adults and juveniles. It is located in the village of Flockton, midway between Huddersfield and Wakefield. New Hall was originally used as a satellite prison for HMP Wakefield. In 1961, its role was changed and it held young adult males. In 1987, it was converted to a women's prison. There are 367 certified normal accommodation places at the prison. The operational capacity (the maximum number of prisoners who can be held) is 426. On the morning of 2 February, 338 prisoners were in custody at the prison.

80. In November 2003, Her Majesty's Chief Inspector of Prisons (HMCIP) inspected New Hall and her report was published in April 2004. She referred to the vulnerability and needs of many of the prisoners. She observed that an average of 75 suicide watch forms were opened each month, that there had been 124 incidents of self harm in the month before the inspection, and that all the in-patients in the Healthcare Centre were severely mentally ill.

81. HMCIP reported that there had been four self-inflicted deaths at New Hall in 2002 and 2003. The introduction to the report states that:
"New Hall is holding women and girls who should not be there. They include those who are seriously mentally ill, as well as some women and girls with high levels of self harm, linked to abuse, including substance abuse. Staff at New Hall were doing their best to provide a stable and safe environment, but were unable to do more than contain the level of need of some very damaged individuals. Prison was likely to increase their vulnerability and mental disorder, in some cases with tragic consequences; and caring for them meant that there was too little time to provide positive interventions for the less damaged women and girls. There is an urgent need to provide alternative, therapeutic environments where appropriate treatment and support can be offered."

82. HMCIP wrote in enthusiastic terms about the CSU, remarking that it was bright, clean and well maintained. She and her colleagues saw CSU staff deal professionally with some difficult women, and showing a great deal of care. They found that the work in the CSU was of the highest standard and represented very good practice. They observed efforts to return prisoners to normal location wherever possible. They also noted that some prisoners, who should probably not have been in prison, either had great difficulty surviving on the wings or would be a danger to others. They considered that every effort was made to provide a reasonable quality of life for the women in the CSU. Their overall conclusion was that the CSU was a good facility which provided excellent standards of care to some troubled women.

83. My present responsibilities for investigating the deaths of all prisoners in England and Wales began on 1 April 2004. Between April and October 2004, I investigated three apparently self-inflicted deaths at New Hall. These deaths have not yet proceeded to inquest, but there are a number of apparent links between the death of the woman and the three fatal incidents between April and October 2004. Two of the three women who died in 2004 had lengthy

histories of self harm, and extensive contact with psychiatric services. The prisoner who died in October 2004 was located in the in-patient section of Healthcare, and was found hanging from a toilet door in a ward there.

THE LAST WEEK OF THE WOMAN'S LIFE

84. On Sunday 30 January 2005, the woman was placed on report by an officer for allegedly using insulting words to him. The incident happened at approximately 2:05pm. Just 20 minutes after using abusive and insulting words to the officer, a nurse found the woman with a ligature tied around her neck.

85. When the woman appeared the next day in front of a governor, she pleaded guilty to swearing at the officer and said she had been in an angry mood. The governor imposed a caution - the lightest possible punishment - for her breach of Prison Rules.

86. The next event of significance was recorded in the woman's F2052SH by a Chaplain during the morning of Tuesday 1 February. When asked about her record, the Chaplain said that she and the woman were chatting about their respective weights and having a laugh about the Chaplain's weight. The Chaplain's impression was that she seemed to be happy that she was no longer in the CSU. In Healthcare, she had the opportunity to mix with other women "and they were only a small number of women, so I think she felt ok with that". The Chaplain recalled that the woman's mood did not change as she went on to speak about hanging herself in the toilet. The Chaplain felt that she was a lot happier than on many other occasions when she had seen her, but she recorded the information in F2052SH and also spoke to a nurse in the office. The Chaplain told the nurse of the woman's opinion that she could not be seen while she was in the toilet area of her cell. The nurse assured the Chaplain that the woman could be seen and the Chaplain was reassured.

87. The F2052SH indicates that on Wednesday 2 February, the woman was in an education class, under constant supervision, between 9:00am and 9:45am. In interview, the course tutor for Healthcare Education described the woman as a willing student, who was reticent at first in his classes, but within a few days chatted and interacted quite well with other people. The tutor taught her during the morning of 2 February, but his main recollection was of the F2052SH review that he attended in the afternoon. His governing memory was that she seemed comparatively upbeat and made a couple of little jokes about food. The tutor said:
"During the morning education session and during this (afternoon review) meeting, I had absolutely no reason to think that [the woman] was down, if anything she was going the opposite way."

88. The F2052SH then shows that the woman moved from the Education class to the chapel at 9:45am. My investigators conducted a lengthy interview with the Chaplaincy volunteer. She explained that she had been meeting the woman on and off for a number of years at the request of one of the Chaplains. She said that the woman found it difficult to make relationships with people. She added, "I suspect it was quite a while before she felt she could trust me, but she did trust me … whenever I saw [the woman] as we parted for the rest of the week, we always had a hug, it was that sort of relationship."

89. The meetings between the volunteer and the woman took place in the prison chapel. The volunteer would collect the woman from her cell, usually in the CSU, then return her at the end of their one to one meeting. The meetings lasted on average about an hour. She said that she tried to give the woman a bit of normality. She would start off their sessions by asking her what sort of week she had had, what she had been watching on television and how she was feeling.

90. She recalled that the woman's mood at the beginning of their meeting on 2 February was "quite jolly really, she wasn't down as I had seen her in the past, she was smiling, she linked arms with me, we walked down to the chapel together, she was quite jovial". When asked to explain why the woman could have been in a good mood that day, the volunteer replied that she told her what she had been doing in Healthcare. She enjoyed taking part in education, had something to do and was not just watching television. The volunteer described the woman as quite a bright girl, and observed that she had more education opportunities in Healthcare than had been the case in the CSU.

91. The second reason for the woman's good spirits, according to the volunteer, was that she was due to go to court the following week. She had talked about the court appearance, and said she might be admitted to a unit near her family. She had told the volunteer that, at long last, she might get some help from that unit and was positive about the prospect.

92. The volunteer's recollection was that her session with the woman that day lasted approximately three quarters of an hour, and ended at 10:30am when she escorted her to the Probation office. The volunteer said she was shocked when she was told that the woman had hanged herself. She said that her death was a shock as the woman had seemed happier, was looking ahead and seemed more positive. She summed up the woman's mood on the morning of 2 February as follows:
"I thought she was in good spirits, I mean I have seen [the woman] when she has been down but she was bright and breezy and that is why it was such a shock when I was told what had happened, I couldn't understand it."

93. The woman was escorted by the volunteer to see the probation officer. In interview, the probation officer said that she had supervised the woman in the community in 2000. At that time she was quite concerned about her, and thought she appeared mentally unwell. She had spoken to the woman's GP who said that he would refer her to see a psychiatrist. The probation officer first saw the woman at New Hall on 24 January 2005, shortly after she had been transferred to Healthcare. She asked the woman why she had stopped eating, and she replied that the voices in her head were telling her that she was "a big fat slag". On 1 February, the woman asked to see the probation officer. She said she wanted to ring her solicitor to see how things were coming along with her court case and about the possibility of admission to the unit near her family.

94. The probation officer telephoned the woman's solicitor whilst they were together on 2 February. The solicitor said that a psychiatrist would be coming

to see the woman about admission to the unit, and it would be after her next court appearance. The probation officer said that the woman was pleased with the news. She would have liked the visit before the next court appearance, but knew that these things did not happen quickly.

95. The probation officer also recollected that the woman brought a document with her. She had been in contact with the National Self Harm Association previously, and wanted to get back in touch so that she could have some more support. While the woman was with her, the probation officer made several telephone calls in an attempt to trace the organisation. Eventually, she left a message on an answer phone at a self harm organisation. She said that the woman was pleased because they had been very helpful to her in the past. During the F2052SH review in the afternoon of 2 February, the probation officer promised the woman that as soon as the self harm organisation returned her message she would pass it on to her.

96. The F2052SH suggests that the woman returned to Healthcare at 11:15am, though the probation officer's recollection is that the woman spent a good hour with her, after the session with the volunteer. At 12:30 pm, a nurse recorded in the F2052SH:
'Failed to respond to check, Orderly Officer informed and cell entered. Breathing noted.'

97. In interview on 1 April 2005, the nurse who was asked for advice by the male nurse when he found the woman, spoke about that incident. She said that she heard the nurse who made the entry on the F2052SH tell another nurse that, during the lunchtime period, they asked for assistance to go into the woman's room because she was not responding. She was lying in bed, with blankets covering her head and body. When the nurse called her by name, she did not respond. When the nurse had assistance from officers, she went into the room and satisfied herself that all was well.

98. The woman's F2052SH review took place at 2:30pm on 2 February. It was a well-attended, multi-disciplinary review with three representatives from Healthcare, including the male nurse, as well as the probation officer, the tutor and the woman herself. The review was chaired by a Senior Healthcare Officer (SHO). The purpose of the review was "to share information on how the prisoner is coping and reach team decisions on what further action needs to be taken to address underlying needs".

99. The summary of the review stated that the woman had tied a ligature on 30 January. She said that she had started eating the previous Saturday and was feeling much better. Even though she was doing well, the summary noted that she was still not very stable and remained a self harm risk. It was decided that she should remain in Healthcare on an open F2052SH with 30 minute observations.

100. The support plan for the woman included making links with the gym which she had said she would like to attend. She was to be encouraged to continue

eating an appropriate diet and to join purposeful activity. The support plan also noted that she was to remain on 30 minute observations.

101. The last prisoner to have significant contact with the woman was located in the cell next door in the upper Healthcare. The prisoner remembered being in a relaxation class with the woman during the afternoon of 2 February, after which they had tea with the other prisoners from the class. She said that the woman seemed quite happy at tea time. The two women were giggling about things that had happened in the class, and she thought that the woman seemed quite happy and contented. My investigator asked the prisoner if anything happened at tea time to upset the woman afterwards, and she replied "she didn't get upset about anything, she was alright". The prisoner thought that she and the woman were locked in their cells at about 5:00pm. This time corresponds with the penultimate entry in the F2052SH made by the male nurse who states that she was locked in her cell at 4:50pm.

102. On the evening of 2 February, the staff on duty on the upper in-patients landing were the male nurse and two prison officers, one male and one female. The normal routine was that the two prison officers arrived at 6:00pm, to be briefed by the nurse on duty, before unlocking the women for association in the Association room at the end of the landing. During this evening shift, there were three other nurses on duty in various parts of the prison. The nurse who worked closest to the male nurse was in the Nurses' Office on the lower level of Healthcare, dispensing medication to Residential One prisoners.

103. It has been difficult for my investigators to establish the precise time when important events happened between 6:00 and 6:30pm. The three staff on duty in in-patients and the nurse dispensing medication all wrote statements later on the evening of 2 February. Some of the timings in their statements are inconsistent with each other. There is further inconsistency between the statements taken that day and what they told my investigators when they were interviewed some weeks later.

104. On 2 February, the female officer wrote that she found the woman at 6:10pm, and the male nurse wrote that he was called to the cell at approximately 6:10pm. The female officer was the first person to find the woman. She initially looked through the observation hatch of her cell but could not see her. She shouted her name and opened the door, thinking that she was using the toilet or standing at the sink. She got no reply, and so she looked into the toilet area in the corner of the cell where she saw the woman in a kneeling position. There was a ligature, made from a piece of green towel, around her neck. It was attached to the hot tap. The officer pulled out her safety knife and called her male colleague into the cell.

105. The male officer cut the ligature away from the knot. In his statement, he wrote that there was no response from the woman at this stage. The male nurse instructed the officers to place the woman in the recovery position so that he could observe her. The male nurse's statement of 2 February indicated that he could feel a light pulse, but that the woman did not respond to verbal or painful stimuli.

106. In interview on 1 March, the male nurse recalled that the woman was slumped against the sink area when he first saw her. The staff moved her out of the toilet area because it was quite confined, and she was placed initially on the floor of her cell. The male nurse tried to get the woman to respond by calling her name and applying pressure to various points in her body. When that did not appear to be effective, he said that he asked the female officer to remain with her while he obtained oxygen from the pharmacy. The pharmacy is just a few doors along the corridor from the woman's cell.

107. The male nurse explained that he chose to move the woman from the cell floor to her bed when he was administering the oxygen. He did so because he thought he could detect a slight pulse and he felt the oxygen would be more effective if she was at a height. Despite the fact that the woman did not respond to verbal and painful stimuli, and he considered it necessary to administer oxygen, no calls for assistance were made at this time to any other parts of the prison. In interview, the male officer on duty said that he was attempting to supervise the other women who were on association, while the nurse and the female officer stayed in the cell with the woman. The cell door was mainly shut, and he said he could not see inside from where he was standing. He estimated that about five minutes passed before the male nurse came out of the cell to collect the oxygen cylinder.

108. The male nurse said that, once he had collected the oxygen cylinder, he put the mask on the woman and turned the oxygen on but it had no effect. He and the other nurse both carried radios, but he left the woman for a few moments to go to the Nurses' Office across the corridor and telephone his colleague. He said that he explained "what had happened, what we are trying to do and could she, you know, give us some assistance". The male nurse's statement on 2 February indicates that he summoned his colleague at 6:15pm, then applied a defibrillator machine to the woman at 6:16pm and commenced cardio pulmonary resuscitation (CPR).

109. The male officer's statement times the arrival of the second nurse at approximately 6:16 or 6:17pm, and further states that she instructed him to telephone for an ambulance at approximately 6:30pm. Apart from the male nurse's telephone call to his colleague, there is no evidence of assistance being requested prior to 6:30pm by means of an alarm bell or radio message.

110. The second nurse's statement on 2 February mentions the telephone call received from the male nurse. She said that "he said inmate [the woman] had been found in her cell with a ligature around her neck and was unresponsive. I advised him to monitor her vital signs and check her pupils."

111. In interview, the second nurse said that she received a phone call from the male nurse requesting advice, not assistance. She did not detect any urgency in his voice and so, after advising him, she continued to issue medication for a further eight to ten minutes by her own estimate. After finishing dispensing medication, she decided to ''nip upstairs to make sure everything was alright.'' When she arrived, the male nurse was alone in the cell with the woman. Apart

from the two officers and the male nurse, there were no other staff in the in-patient unit.

112. The two nurses collected emergency equipment, attached the defibrillator and oxygen and began to administer CPR, which had not been attempted until then. They said that the defibrillator did not advise them to administer an electric shock to the woman, so they continued with CPR until the paramedics arrived at approximately 6:50 pm by the second nurse's timing.

113. During the interview conducted by my investigator and the clinical reviewer on 21 June 2005, the male nurse explained why there was no oxygen in the woman's cell by the time the second nurse arrived. After the woman did not respond to painful stimuli he had obtained an oxygen cylinder from the pharmacy directly across the corridor from the nurses' office. He was asked for how long he administered oxygen to the woman before reinforcements arrived. He answered: ''At that point, when that (administering oxygen) still wasn't effective, then that was when I returned the oxygen and phoned for [the second nurse].''

114. There is no dispute that the emergency bag in the Nurses' Office, containing a defibrillator and other emergency equipment, was not obtained until the second nurse arrived. CPR did not begin until she arrived at the cell.

115. The second nurse is very experienced. On the day of her interview, she had been nursing for exactly 25 years, of which the last 13 had been at New Hall. She had been trained in the use of the defibrillator, and had used it on two or three occasions prior to 2 February 2005. The male nurse was not trained in first aid but had done some resuscitation and defibrillator training at the end of 2004. He had not had an opportunity to use his training in earnest before 2 February 2005.

116. The second nurse explained that the automatic defibrillator machine tells staff what to do. The machine did not instruct staff to administer an electric shock to the woman, but did tell them to commence CPR. The male nurse carried out chest compressions whilst she administered oxygen. In due course they were joined by a Senior Officer (SO). Then the second nurse held the mask to the woman's face and the SO tried to force oxygen into her lungs by squeezing the ambu bag.

117. The male officer's statement written on 2 February suggests there was a time delay of approximately 13 minutes between the second nurse's arrival and her instruction to him at approximately 6:30pm to telephone for an ambulance. At his first interview on 1 April, his view was that the time gap was much shorter than 13 minutes and seemed "about five minutes". He was asked by my investigator about the very precise times recorded in his statement on 2 February. The officer replied that the times he recorded were those agreed at the de-brief meeting, held later in the evening. He appears to have relied on the collective times agreed at the meeting, and indeed said in interview: "I mean the times come from everybody, I accept that this is my statement but at the time I agreed with the times."

118. The second nurse was scathing about the de-brief meeting. She said:
"I think that things were written on a white board, times were written on a white board in the association room and we were instructed this happened at this time, this happened at this time and I saw it as this is assisting us in writing our statement and I just went along with it, I was overwhelmed, there was probably eighteen people in that room that weren't directly involved in this case and it was very overwhelming … I was expecting de-brief and we didn't get one, we got a memo writing session it was."

119. The second nurse was insistent that the first thing she said when she arrived at the woman's cell was that an ambulance should be called straight away. In her second interview, she said that it was her professional opinion that the woman was already dead or near death when she arrived, and she provided a considerable amount of technical information to explain why that was her opinion.

120. The telephone evidence discussed later in this report leads me to conclude that the second nurse did indeed issue instructions for an ambulance to be summoned very soon after her arrival in the upper healthcare centre. The first entry in the control room's Incident Occurrence Sheet is at 6:36pm and the event recorded is:
Request by [the male officer] via landline to phone for 999 ambulance at [the second nurse's] request.

121. The control room made a 999 telephone call to the ambulance service at 6:37pm, and the arrival of the ambulance in the prison is recorded at 6:52pm. Staff from other parts of the prison arrived at Healthcare soon after the male officer's telephone call to the control room. The SO assisted the two nurses as they gave the woman oxygen and chest compressions.

122. A witness statement signed by one of the ambulance technicians indicates that, at 6.50pm on 2 February, he attended New Hall prison. He examined the woman and diagnosed that life was extinct at 6:56pm.

FOLLOW UP BY THE PRISON AFTER THE WOMAN'S DEATH

123. After the woman's death a letter to her mother was discovered in her cell. The letter appears to suggest that she intended to take her own life. Parts of the letter read as follows:
"The voices were becoming really bad and I didn't feel I was getting any help for them so I decided to get rid of them good and proper by hanging myself off the taps like I said I would.
"At the end of the day I was in a camera'd room and they should have been watching me constantly because I also told the Chaplain the other day what I was going to do."

124. Her letter also included a request for a particular song to be played at her funeral.

125. At 8:30pm on the day of the woman's death, one of the Chaplains and the Governor went to the address given by the woman for her mother. There was no response from inside the house so the Chaplain telephoned the mother on a mobile phone number that the woman had also supplied. The Chaplain broke the news of the woman's death to her mother during that telephone call. The mother told them that she was actually living a few miles away from the address given by the woman. The Chaplain and Governor drove there and spoke with the mother in person.

126. On the morning after the woman's death, the Head of Safer Custody went around the prison breaking the news in person to groups of prisoners. I commend him for his actions which were admirable and an example of very best practice.

127. Swift and sensitive arrangements were made to deliver the woman's property to her mother.

128. The woman's funeral service took place two weeks after her death. At the request of her mother, the prison Chaplain conducted the service. Her mother was invited to visit the prison after the woman's death and has done so. There has been regular contact, both by telephone and in person, between the mother, the HSC and the Chaplain. The cost of the funeral service was met by the prison.

THE WOMAN'S COMPLAINT, UNDER CONFIDENTIAL ACCESS, ON 10 JANUARY 2005

129. Prisoners have a right to make formal written complaints under confidential access to the governing Governor, Area Manager or Chairman of the IMB. The woman wrote on the complaint form that she wanted to make a complaint about the HSC. She said that her mental health had become worse, and she was severely depressed and suicidal, not because she was in the CSU but because of the HSC. She complained that he had put her in cell 2 for about one and a half days, and that he had stopped her mail coming in and going out of the prison.

130. Most regrettably, the HSC had no opportunity to respond to these allegations before the woman's death. When the woman made her complaint, the usual Complaints Clerk was on leave and her colleagues attempted to deal with it on her behalf. The complaint was sent in a sealed envelope to a senior Prison Service manager at his office. The senior Prison Service manager had previously had responsibility for all female prisons, but in April 2004 management responsibilities were changed and the area manager for Yorkshire took over. The senior manager's office returned the envelope to New Hall, and it was not forwarded to the correct area manager until 1 February. The complaint was received at the correct office on 3 February, the day after the woman's death.

131. The HSC was unaware of the complaint until 15 March when he was interviewed by my investigator. I am entirely certain that the woman's complaint was wrongly directed because of an administrative error rather than as a deliberate attempt to impede investigation of the issues raised. I am very sorry indeed that the error resulted in considerable distress for the HSC. It is clear to me that he invested a great deal of time and effort in doing the very best for the woman that he could. Although he offered a vigorous rebuttal to her allegations when interviewed by my investigator, he should have had the opportunity to respond to them whilst she was alive.

I recommend that the Governor reminds the relevant staff of the correct procedures and address to be used for confidential access complaints.

132. The woman's solicitors wrote to the HSC on 19 January. They told him of her concern that letters she had recently written had not been received by various individuals. They asked him to enquire whether her post was being diverted or delayed in any way. He replied on 25 January after checking with the prison's mail room. He assured the solicitors that there were no restrictions regarding her mail, and that no letters had been stopped.

133. In response to the woman's complaint to the manager that the HSC put her in cell 2 in the CSU for about one and a half days, he recalled taking some action some time in early January. He received a call on a Saturday evening that she had blocked off her observation panel in the CSU and was not responding to staff. Her door was barricaded and staff were unable to open it. The HSC went himself to the CSU, and he could not get a response from her either. He

was concerned about her safety because he did not know whether she had a ligature. He explained how staff opened the door outwards, and then re-located her to cell 2 in the CSU. Cell 2 has a drop down flap in the door, which enables staff to observe directly what is happening inside the cell. Other CSU cells have glass panels and, if they are blocked, staff cannot see clearly into the cell. The barricade took place on a Saturday evening and the HSC said that his strategy was to ensure that staff were able to observe the woman throughout the coming night. He added that the cells in the CSU are cleaned to a very high standard, and are all clean and tidy before prisoners are located there.

134. The HSC's recollection that the woman was moved to Cell S1-2 on a Saturday is confirmed by an entry in the Staff Observation Book maintained in the CSU. The second entry for Saturday 8 January states that she "blocked obs panel off, would not talk to anyone, cell was entered and [the woman] was relocated to Cell S1-2. [the HSC's] instructions."

135. As indicated elsewhere in this report, Sunday 9 January was a very disturbed day for the woman with self harm incidents taking place at 8:30am, 12:35pm and 6:40pm. At 3:50pm that day, she told a Chaplain that she would hang herself. At 10:25am, staff entered her cell after they could gain no response from her. She jumped out of bed and lunged at one officer, before attempting to grab a second officer around her head, knocking the officer's glasses across the floor.

136. The HSC was so concerned about her unpredictable and volatile behaviour that day that he gave instructions for her to be unlocked by three staff rather than the usual two. A further entry in the Staff Observation Book on 10 January notes that she was relocated in Cell S1-9 from Cell S1-2, and the unlock level was reduced from three to two staff.

137. The woman wrote her formal complaint under confidential access on 10 January. It is reasonable to conclude that her reference to being located in Cell S1-2 refers to the weekend she had just spent there.

TIMES OF TELEPHONE CALLS TO AND FROM THE UPPER HEALTHCARE CENTRE

138. After the first round of interviews with the two nurses and two officers on duty on the night the woman died, my investigators commissioned information about telephone calls made to and from the upper Healthcare centre between 5:30pm and 6:45pm on 2 February. The information was requested because of the conflicting timings in the statements and interviews of these four members of staff.

139. The prison's current telephone list indicates that extension 4395 is located in H Wing (upstairs). This is the Nurses' Office in the in-patient part of Healthcare. A report was created on 26 April which shows that a number of telephone calls were made to that extension between 5:35 and 6:13pm on 2 February. At 6:21:06, a brief telephone call was made from extension 4395 to extension number 4277, which is the wing centre in the Residential One area. The next call was at 6:30:41, made to extension 4230 which is the prison's control room. This call lasted 44 seconds and was from the male officer to request that an ambulance be called.

140. My investigators were then informed that there is a second telephone, extension 4294, in the Nurses' Office of upper Healthcare. On 6 May, a report was created showing phone calls to and from that extension between 5:30 and 6:45pm on 2 February. Between 5:30 and 6:20pm, there were no calls to or from extension 4294. At 6:22:51 an attempt was made to call extension 4340, which is the Nurses' Office in the out-patient part of the Healthcare Centre, but the call was not answered. At 6:23:37, another call was made to extension 4350 which is shown as Pharmacy in the current telephone list. The telephone numbered 4350 is situated just beside the hatch in the downstairs Nurses' Office, through which the second nurse dispensed medication to prisoners from the Residential One area. On this occasion, the telephone was answered and a conversation of 47 seconds duration took place. This is the telephone call in which the male nurse asked the second nurse for advice about the woman. The next recorded call did not take place until 6:38:39 and was a call to extension 4294.

141. These telephone call records therefore show that the male nurse did not speak to the second nurse for advice until 6:23:37. A further seven minutes passed before the call to the control room, at 6:30:41, which asked for an ambulance to be summoned. The delay of seven minutes is almost entirely consistent with the second nurse's estimate in interview that eight to ten minutes passed between the male nurse's call to her and her own arrival at the woman's cell.

THE WOMAN'S LOCATION IN THE SEGREGATION UNIT

142. Information obtained from the woman's previous prison records indicates that she spent lengthy periods in segregation units prior to arriving at New Hall on 9 November 2004. The Chaplaincy volunteer knew her very well and shared confidences with her. She told my investigators that the woman preferred to be held in a CSU because she found it difficult to make relationships with other people, especially when they were in large groups.

143. The woman was issued with a piece of statement paper at 12:35pm on the afternoon of her arrival at the prison, and she wrote that she wished to be located on the CSU for her own protection. A Segregation Safety Algorithm was completed. This states that she was first placed in the CSU at 1:55pm. A registered nurse or doctor is required to complete Parts A and B of the Algorithm. In this case, a Registered General Nurse (RGN) completed Part A of the form although Part B was left blank.

144. The second question in Part A enquires whether the prisoner has self harmed during this period of custody or is on an open F2052SH. The RGN answered yes to that question, but no to the following question which is: "Do you think the prisoner's mental health will deteriorate significantly if segregated?" At the end of Part A the RGN has not recorded an opinion as to whether ''there are or are not healthcare reasons to advise against segregation at this time.'' I assume the nurse was of the opinion that there were no healthcare reasons to advise against segregation. All the boxes ticked in the first part of the algorithm lead to a shaded conclusion at the bottom of the first page of NO HEALTHCARE INTERVENTION AT THIS TIME. (capital letters in original form)

145. Part C of the form requires the Duty Governor to decide whether a prisoner is to be segregated or not. There are two important points to be considered at this stage by the Duty Governor. The first is that a prisoner on an open F2052SH must only be located in the CSU in exceptional circumstances which should be described on the form. An F2052SH had been opened on the woman by the male nurse following information obtained during her First Reception Health Screen. The HSC decided that the woman should be segregated, but did not record any exceptional circumstances to justify his decision. When the HSC talked about his decision with my investigators, he said that the woman was well-known to prison staff from her previous periods in custody. The HSC consulted staff about her request for segregation, and was told that her time in custody was mainly in the CSU because she always requested protection "and that was the norm for [the woman] when [she] came into custody at New Hall".

146. Prison Service Order 2700 on Suicide and Self Harm Prevention contains advice on Segregation at Chapter 4.1.2 of the document. The PSO states: "Prisoners who are at risk of suicide or self harm must not be routinely held in the Segregation Unit under Rule 45 GOOD unless, exceptionally, they are such a risk to themselves or others that no other suitable location is appropriate. Such prisoners must only be placed in a Segregation Unit in exceptional circumstances, or where all other options have been tried, but

considered inappropriate ... If the decision is taken to locate prisoners at risk of self harm within the Segregation Unit this must be for as short a period of time as possible, and the temporary nature of this must be reflected in the care plans."

147. There is no evidence that all other options were tried but considered inappropriate on 9 November 2004. However, there seems to be no doubt that the CSU was where the woman wanted to be located. Her written application confirms that fact, and previous prison records state how difficult it was to move her out of the CSU at New Hall, Buckley Hall or other prisons.

148. The decision to segregate her under Prison Rule 45 had to be reviewed within 72 hours, and this duly happened. The Segregation Review Board on 12 November was chaired by the HSC, and attended by the woman herself. A nurse also attended, as did a member of the prison's IMB. The form used by the Review Board asks whether there are any specific concerns about the mental health of the prisoner or the risk of self harm. The HSC recorded that the woman had a history of self harm and overdose but noted that there were no mental health issues.

149. Further reviews of her segregation took place on 17 November, 1 December, 15 December, 29 December and 12 January 2005. She herself attended some of these reviews but refused to attend others. The review on 17 November noted there were no mental health issues but spoke of self harm issues. On 1 December, the Specific Concerns section of the form noted that she was awaiting psychiatric assessment, and on 15 December the same section stated that she was to be assessed by a psychiatrist. The woman attended all of that meeting, but refused to attend the next one on 29 December 2004. The Specific Concerns section of the document noted that she was currently on an F2052SH, but there had been no self harm incidents for a couple of weeks. There was a known eating disorder, which was highlighted in the general notes about her behaviour at the Segregation Reviews on both 15 December and 29 December 2004.

150. The woman wrote her letter to the HSC on 22 December, but the letter is not referred to at either the review on 29 December or the next one on 12 January 2005.

151. The review form completed on 15 December noted that she was to be assessed by a psychiatrist, and this did indeed happen immediately before Christmas, but there was no further reference to psychiatric assessment in subsequent reviews. At the review on 12 January, some thought was given to transferring her to another prison if she continued not to engage with the regime at New Hall. The next review was scheduled for 26 January 2005, but prior to that date she was transferred to Healthcare.

OBSERVATION OF THE WOMAN BETWEEN 4:50PM AND 6:15PM ON 2 FEBRUARY 2005

152. In the Daily Supervision and Support Record section of the woman's F2052SH, the penultimate entry was made at 4:50pm by the male nurse. He recorded that she was locked in her cell. There were no more entries until the last entry at 6:15pm, also made by the male nurse. It states that she was found with "ligature to neck". The Case Review, which the male nurse had attended, was held less than four hours earlier and had confirmed that the woman was to remain on 30 minute observations.

153. My investigators asked the male nurse about observation of the woman between 4:50pm and 6:15pm, and asked whether she had been observed between those times. He replied:
"[The woman] was observed although we don't necessarily record that in this document, [she] will have been checked twice between the lock-in period and just after 6:00pm when we unlocked her."

154. When asked about his reply the male nurse added that there was a policy in HCC at that time to the effect that:
"We didn't actually have to record every half an hour, only if something significant happened so if during those checks [the woman] was observed to have been on the floor that would have been documented, if we observe [the woman] and there were no areas for concern, then we wouldn't necessarily record anything, quite standard in the Healthcare department."
He said the policy had been written down by a Senior Officer who was no longer working at the prison.

155. The male nurse was asked who made checks on the woman between 4:50pm and 6:15pm. He said he had made the checks himself, "and the reason I know that is we had another lady who was on four entries an hour and the policy at that point is if anybody was on more than two observations an hour it had to be documented, so I had to check the other girl every fifteen minutes and that is documented". He said that the other prisoner was in a cell three doors down from the woman. The last official check on the other prisoner was recorded at 6:00pm and, as it was conducted, the male nurse would have walked past the woman's cell and glanced in.

156. My investigator made contact with the former Senior Officer in the Healthcare Centre. He is now the Healthcare Manager at HMP Moorland. He supplied a memorandum (headed 2052SH observations) which includes the following:
"Most, if not all, prisoners located on the Healthcare Centre would have had specified observation levels and I would expect staff to record their observations in writing at those specified intervals of time. The only exception to this would be if staff were constantly in the presence of a prisoner for longer than the specified observation period and providing this was accurately recorded it would be acceptable to make one entry to cover that period."

157. At the time of the woman's death, the prison's policy on suicide prevention was entitled Suicide and Self Harm Prevention Policy and Procedures. It was

issued in October 2003 and was due to be reviewed in October 2004. It was to be replaced by a new policy but, at the time of her death, the local policy was that set out in the October 2003 document. It states at paragraph 3 on page 12 that all prisoners subject to F2052SH procedures and in a single cell will be observed at irregular intervals, as the support plan indicates. The policy then adds in bold type that these observations must be recorded.

158. My investigators examined all the F2052SH documents that were open in the Healthcare centre on 2 February, the day that the woman died. There were three other women on open forms 2052SH in the upper Healthcare.

- Prisoner JR was locked in by the male nurse at 4:50pm, and then there are three entries on her Support Record made by the male officer at 6:00pm, 6:30pm and 7:00pm. The entry at 6:00pm notes no sign of self harm, but the figures in the Time column have been altered, and it is not possible to see the original entry.

- Prisoner EC was also reviewed on 2 February, and it was decided that she should be observed at 30 minute intervals in the camera room. In this case, an entry made by the male nurse at 5:10pm indicates that the prisoner was locked in after a cigarette. The next two entries on the Support Record were made by the male officer at 6:00pm and 6:30pm. They report no signs of self harm.

- During the morning of 2 February, prisoner JE smashed up her room and broke her television. She was surrounded by broken glass and cut her arms with the glass. A new F2052SH was opened by an SO, and it was decided that there must be four observations per hour. JE is the woman to whom the male nurse refers at paragraph 155 of this report. Her cell was in the corner of the landing. He had to pass the woman's cell to reach JE's cell. The Daily Supervision Record section of JE's F2052SH does show that the male nurse made 11 consecutive entries, beginning at 3:45pm on 2 February. Entries were made every 15 minutes from then until 5:45pm. His final entry was made at 6:05pm, with the following two entries, at 6:30pm and 6:45pm, made by the male officer.

159. The investigators also examined tea time entries in the woman's own F2052SH for the days immediately prior to her death. She was in Healthcare on an open F2052SH between 21 January and 2 February.
    - On 21 January, she was observed half hourly at tea time.
    - On 22 January, she was observed at 4:50pm, 5:23pm and 6:00pm by a Nursing Auxiliary (NA).
    - On 23 January, she was observed every half hour and this was again the pattern on 24 January.
    - On 25 January, recorded observations were made at 4:55, 5:30 and 6:10pm.
    - On 26 January, the male nurse was on duty and the record shows that she was locked in at 4:55pm and then the next entry was made at 6:20pm.

- On 27 January, she was observed every half hour.
- On 28 January, the male nurse was again on duty and there were no half hourly observations.
- On 29 January, the NA was again on duty and she was observed every half hour.
- On 30 January, another nurse was on duty and she was observed every half hour.
- On 31 January, a further nurse was on duty and observed her at 4:55, 5:30 and 6:20pm.
- On 1 February, she was observed at 5 pm then not until 7:45pm. The entry in the support record at 7:45pm was made by a prison officer.

160. Analysis of this information shows that the woman spent 13 tea times in Healthcare between 21 January and 2 February. On ten of those thirteen occasions, she was observed at half hourly or almost half hourly intervals over the tea time period. On 26 and 28 January, when the male nurse was on duty, there was no recorded observation of her during the tea time period. On 1 February, there was no recorded observation between 5:00pm and 7:45pm. The male nurse's understanding that observations need not be recorded thus appears to be at variance with the practice of his colleagues, apart from the member of staff on duty from tea time on 1 February. Since the woman's death this officer has retired and it was not possible to interview him.

CONCLUSIONS

161. The deceased was a young woman who had harmed herself on numerous occasions prior to her death. She had most recently tied a ligature round her neck on 30 January, just three days before her death. However, the consensus of opinion about her around the time of her death was that there were several reasons for optimism. The members of staff who attended the final F2052SH review on the afternoon of 2 February felt very encouraged about her. The move from the CSU to Healthcare seemed to be going well. The SO who chaired the meeting thought that she was looking ahead to the future. She had expressed an interest in going to the gym, was interacting on Healthcare, attending education, eating again and there was the possibility of a place for her at the unit near her family.

162. As well as talking to staff at the meeting, the woman also spent time that day with education staff, with the prison's Probation Officer and with the Chaplaincy volunteer. She did not indicate to any of these people that she intended to harm herself that evening. The poignant letter left by her for her mother appears to suggest that she intended to take her own life, as she named a song that she wanted played at her funeral. She refers to the voices in her head becoming really bad and her decision to "get rid of them good and proper by hanging myself off the taps like I said I would". From the available evidence, I am unable to conclude whether the woman made this decision just a short time before her death, or whether she had formed the intention previously.

163. One of the questions raised by the woman's mother is whether she should have been constantly watched, given her frequent attempts to harm herself and hang herself. I conclude that half hourly observations were a reasonable response to the perceived level of risk. Her risk of self harm was regularly assessed, and the most recent Case Review took place just a few hours before she died. It was attended by staff from a wide range of disciplines, including education, Healthcare staff, and the prison probation officer, as well as the woman herself. The summary of their discussion did not ignore the ligature incident which had taken place three days earlier, but recognised a number of positive factors, particularly her decision to start eating again during the previous weekend.

164. I am unsure whether the woman was observed by the male nurse between 4:50pm and 6:15pm on 2 February or not. He assured my investigators that he did observe her during that time, although he made no entries on F2052SH. He explained that he was acting in accordance with instructions issued by an SO. The SO's memorandum about the subject states his expectation that staff would record their observations in writing each time they were made. I am aware that since the woman's death the F2052SH system at New Hall and in many other prisons has been replaced by Assessment, Care in Custody and Teamwork (ACCT). ACCT encourages prison staff to make fewer entries in the ongoing record, but to ensure that entries of significant events, conversations and observations are of high quality. However the system in operation at the time of the woman's death was F2052SH, and the prison wide

policy issued in October 2003 stated in bold type that observations of prisoners subject to F2052SH procedures when in a single cell must be recorded. I make two recommendations in relation to this matter.

The Area Manager for Yorkshire and Humberside in conjunction with Wakefield West PCT should consider setting up a disciplinary investigation to establish whether [the male nurse] contravened published observation policy.

New Hall's published Suicide and Self harm Prevention Policy document should clearly state the prison's policy on recording observations of prisoners at risk of self harm. The document should also indicate whether the policy applies in all areas of the prison or not.

165. It is difficult to establish the time when the woman was first found hanging in her cell in the Healthcare Centre, but I conclude that it was probably between 6:10 and 6:15pm. The male nurse's entry in the F2052SH times the beginning of the incident at 6:15pm. Information from staff about the time when the second nurse first came to the in-patient area is contradictory. I attach considerable importance to the telephone records for the two telephones in the Nurses' Office. The records establish that the male nurse did not seek advice from the second nurse until 6:22:51pm at the very earliest. The records also show that a telephone call from the male officer to the Control Room was not made until 6:30:41 at the very earliest. The control room records may be slightly inaccurate because they indicate a telephone call from the male officer at 6:36pm, and a 999 call to the West Yorkshire Ambulance Service at 6:37pm, whereas the Ambulance Service's own record states that the first call from New Hall was at 6:35:44.

166. The telephone records suggest that the male nurse did not appreciate the gravity of the situation, and it appears that he did not know the most appropriate steps to take to attempt resuscitation. The defibrillator was not obtained until the second nurse arrived, CPR was not begun promptly and the woman was placed on a soft rather than hard surface when he prepared to administer oxygen. During my investigation I wrote to the Governor of New Hall about these apparent shortcomings in the male nurse's professional competence.

In light of these findings relating to [the woman's] care, I recommend that the Area Manager and Wakefield West PCT should consider what action is now required, whether by way of discipline or by providing urgent further training for [the male nurse].

167. I make no criticism of the two prison officers on duty in the in-patient area at the time. I accept that they believed that the best course of action in the circumstances was to maintain the association period for the remaining women in the area, whilst trying to provide the necessary support to the male nurse. I recommend that the Governor reviews her contingency plans for responding to major incidents in the Healthcare Centre. The working assumption of staff, as well as documents such as the Suicide and Self harm Prevention Policy, is that

incidents of suicide and self harm are likely to occur outside Healthcare, and Healthcare staff will proceed to other parts of the prison to support other colleagues. The contingency plans should clearly state the actions to be taken if such incidents take place in Healthcare itself.

168. I conclude that the second nurse behaved appropriately and injected the necessary level of urgency when she arrived in the in-patient unit. I note her professional opinion that the woman was already dead or near death when she first got there.

169. The Chaplaincy volunteer was a shrewd and sympathetic friend to the woman for an extended period of time. She said that the woman did not find it easy to mix with people, and found large groups of people very difficult. She felt that was why she asked to be located in the CSU most of the time that she was in prison. The woman herself asked to be located in the CSU as soon as she arrived at New Hall on 9 November, and her request was granted.

170. The Cell Sharing Risk Assessment (CSRA) completed on 9 November stated there was a high level of risk that the woman might assault a cellmate if she shared a cell. When asked by the Reception Officer, she said that she was concerned about sharing a cell, and described herself as a person who quickly got angry and frustrated. Because of the assessment that she posed a high rate of risk of harm to others, the matter of her location was referred to both a duty manager and duty governor. Both agreed that she should be located in a single cell in the CSU.

171. That decision was made despite the recognition recorded on the CSRA that the woman was extremely vulnerable and on an open F2052SH. PSO 2700 states that prisoners at risk of suicide or self harm must not routinely be held in the CSU. They should only be held there in exceptional circumstances, or where all other options have been tried, but considered inappropriate. I have seen no evidence that an alternative to the CSU was sufficiently considered when the woman arrived at the prison. Location of a prisoner on an open F2052SH in the CSU is a matter of last resort.

I recommend that the Governor reminds senior colleagues that the requirements of PSO 2700 must be fully complied with.

172. The woman's Rule 45 status was regularly reviewed between November 2004 and January 2005. Part C of the Segregation Safety Algorithm was not fully completed by the Governor on 9 November. The form requires the Governor to record the exceptional circumstances which justify the location of a prisoner on an open F2052SH in the CSU. The written explanation is not simply a minor procedural matter, but is vital to the safety and well-being of prisoners.

I recommend that the Governor reminds senior colleagues that the requirements at Part C of the Algorithm in relation to explanations for decisions and a record of case conference discussions must be fully observed.

173. At the woman's first Segregation Review Board no mental health issues were noted, but her history of self harm and overdose was recorded. I take the view that a history of self harm should raise specific concerns about the prisoner's mental health being reviewed. The form asks for details of the support to be taken.

I recommend that information about the support available should be recorded at future boards for prisoners who have a history of self harm.

174. Later reviews recorded that the woman was to be assessed by a psychiatrist, but subsequent forms did not indicate whether it happened.

I recommend that review boards improve continuity by following up and recording whether recommendations from earlier boards have been implemented.

175. On 22 December, the woman wrote to the HSC setting out four issues that concerned her. Two issues were medical matters, and the others concerned her daily life in the CSU. I have no doubt that the HSC did his utmost to resolve the issues, but nevertheless the letter should also have been distributed to Healthcare. The woman's concerns about her medication and psychiatric care should have been referred to clinical staff who were competent to handle them. The Governor was telephoned about the woman's mental state on Christmas Eve, and wrote the same day to the Healthcare manager. I consider that pattern should be emulated by her colleagues.

176. The woman's mother has expressed concern about the length of time she spent in the CSU before being transferred to Healthcare. The HSC said that he felt he was acting in her best interests by trying to move her from the CSU to a normal location. He was well aware that a prisoner's mental health may deteriorate if they continue to be located in the CSU for a long time. There is very clear evidence that he was doing his best to move her from the CSU in the letter of 19 January from the woman's solicitor which states: "There is presently concern being expressed by yourself as to why she is on segregation and [her mother] has expressed significant concerns as to the prospect of being removed from the Segregation wing." Once the woman had been admitted to the CSU on 9 November it was difficult to remove her, not least because of her own attachment to the unit. The HSC was clearly making appropriate efforts, and the woman herself was involved in the discussion.

177. The woman's complaint about the HSC did not reach the correct area manager until after her death. The three week delay is unacceptable, but I readily conclude that the delay was due to an error, rather than a deliberate attempt to block a prisoner's complaint.

178. The prompt way in which news of the woman's death was broken to her mother was very good practice. The Governor and the Chaplain went in person to see her mother. When they did not find her at her home, they travelled further to speak to her in person. I commend the Governor for undertaking the task in person and for her determination to speak to the

woman's mother face to face. The way in which the HSC told small groups of prisoners about the woman's death was also most impressive. The Chaplain conducted the woman's funeral service a fortnight after her death. I know that there has been regular support, both by visits and telephone calls, for the mother from the Chaplain and the HSC. Financial support for funeral costs was supplied promptly and sensitively by the prison.

179. I conclude that members of the Chaplaincy team at New Hall offered valued support to the woman and her family. The Chaplain's role in the days and weeks after her death has already been discussed. I pay tribute here to the admirable work over weeks, months and years by the Chaplaincy volunteer. I am aware that she is part of a team of volunteers, but it is right to highlight the enormous support she gave to the woman. She exemplifies the contribution that can be made by voluntary workers in a prison setting. It is probable that only a few friends and neighbours and the New Hall community know about her voluntary work there. She was the only visitor the woman had, apart from her mother. She acted as the woman's champion, trusted friend, advisor and confidante. The two women respected each other, and she had the woman's very best interests at heart. An example is that she persuaded the woman at Christmas time to come to the Carol Service. She agreed to attend as the volunteer arranged for them to sit together, and remain in the chapel until other prisoners left.

I recommend that the Yorkshire Area Manager writes to [the volunteer] to thank her for her voluntary contribution at New Hall over the years, and particularly to draw attention to my comments and to express his appreciation for her practical support and encouragement for [the woman].

180. A second Chaplain was another member of the Chaplaincy team who had valuable contact with the woman. On 9 January and 1 February, she told this Chaplain that she intended to hang herself. On both occasions the Chaplain took appropriate action, making a detailed entry in F2052SH and speaking with relevant staff. On the second occasion, the woman claimed that she could hang herself in the toilet of her cell without being seen by staff. The Chaplain discussed her claim with a nurse, and was reassured that staff were able to see the woman. New Hall is an environment where self harm is a regular occurrence, but this Chaplain did not ignore the woman's claim and responded appropriately to it.

181. I have some misgivings about the hot de-brief conducted on the evening of 2 February. The male officer referred to a structured timescale being agreed at the de-brief and the second nurse complained about the overwhelming number of people who were present. She described it as a memo writing session, with no opportunity for discussion of their feelings about the woman's death. At the time my investigators conducted a second round of interviews in late June, a critical incident de-brief had still not taken place.

I recommend that the Governor reviews and improves the de-briefs at the prison. In particular, staff should write statements independently, and should not be provided with "agreed" timings.

182. The woman's mother asked through her solicitor whether her daughter, with her severe psychiatric history and propensity for severe self harm, should ever have been held in custody, rather than in hospital. I do not know what options the court considered, but I share the view of HM Chief Inspector of Prisons as expressed in her most recent report on New Hall. The Chief Inspector records that New Hall, like other women's prisons recently inspected, is holding women and girls who should not be there. They include those who are seriously mentally ill, as well as some women and girls with high levels of self harm. Prison is likely to increase their vulnerability and mental disorder, in some cases with tragic consequences.

183. Sentencing policy is not a matter directly within my remit. However, no reader of this report can fail to be troubled by the level of distress that the woman experienced and expressed.

I recommend that the circumstances of this case are drawn to the attention of the Local Criminal Justice Board and to the Office for Criminal Justice Reform.

184. The cameras currently in use in the in-patients area of the Healthcare Centre are of limited value. There were insufficient staff to monitor and analyse the images obtained. The cameras do not appear to film the whole area, including the toilet in each cell. Page 9 of the clinical review addresses the issue of situational strategies to remove the means of suicide. The existing cameras create the impression of providing extra security, but it is difficult to measure the actual value. It may well be that the provision of additional safer cells would be preferable to inadequate camera coverage.

I recommend that the Governor reviews the use and value of the cameras in the in-patient centre.

RECOMMENDATIONS

Operational

1. I recommend that the Governor reminds the relevant staff of the correct procedures and address to be used for confidential access complaints.

2. New Hall's published Suicide and Self harm Prevention Policy should clearly state the requirements for recording observations of prisoners who are at risk of self harm. The document should also indicate whether the policy applies in all areas of the prison or not.

3. I recommend that the Governor reminds senior colleagues that the requirements of PSO 2700 must be fully complied with.

4. I recommend that the Governor reminds senior colleagues that the requirements of Part C of the Algorithm in relation to explanations for decisions and a record of case conferences must be fully observed.

5. I recommend that information about the support available should be recorded at future boards for prisoners who have a history of self harm.

6. I recommend that review boards improve continuity by following up and recording whether recommendations from earlier boards have been implemented.

7 I recommend that the Yorkshire Area Manager writes to [the volunteer] to thank her for her voluntary work at New Hall over the years, and particularly to draw attention to my comments and to express his appreciation for her practical support and encouragement for [the woman].

8. I recommend that the Governor reviews and improves the conduct of de-briefs at the prison. In particular, staff should write statements independently and should not be provided with "agreed" timings.

9. I recommend that the circumstances of this case are drawn to the attention of the Local Criminal Justice Board and to the Office for Criminal Justice Reform.

Healthcare

10. The Area Manager for Yorkshire and Humberside, in conjunction with Wakefield West PCT, should consider setting up a disciplinary investigation to establish whether [the male nurse] contravened published observation policy.

11. In light of these findings relating to [the woman's] care, I recommend that the Area Manager and Wakefield West PCT should consider what action is now required, whether by way of discipline or by providing urgent further training for [the male nurse].

12. I recommend that the Governor reviews the use and value of the cameras in the in-patient centre.

Good Practice

In the sad circumstances following the woman's death, I have been most impressed by how the prison then responded. The prompt way in which news of her death was broken to her mother was an example. The Governor and the Chaplain went in person and, when they did not find her at home, they travelled further to speak to her in person. I commend the Governor for undertaking the task in person and for her determination to speak to the woman's mother face to face. The way in which the HSC told small groups of prisoners about the woman's death was also most impressive. The Chaplaincy team also emerge very well from this report. I would be grateful if my comments could be drawn to the attention of all those concerned.