

**Investigation into the circumstances surrounding the death of a woman
on 29 July 2004 at HMP New Hall**

Prisons and Probation Ombudsman for England and Wales

June 2005

FINAL REPORT

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The woman was aged 29 when she died on 29 July 2004 in her cell at HMP New Hall. This is a report into the circumstances surrounding her death. The loss of any family member is distressing, but especially so whilst they are in custody and I offer my sincere condolences to her family and friends.

The investigation was carried out by a member of my office, and assisted by a manager from HMP Northallerton. I would like to thank the Governor of New Hall for making the necessary facilities available to my investigator. I also pay thanks for the help and support of the Liaison Officer for his invaluable assistance.

In the course of the investigation, I asked the Wakefield Primary Care Trust to undertake a clinical review of the care and treatment received by the woman from HMP New Hall, and one was commissioned. The Suicide Prevention Consultant, of the HMPS Women's Team, also undertook a snapshot of the prison's suicide and self-harm procedures and compliance with the relevant Prison Service Order. The Nurse Consultant, Substance Misuse, again of the HMPS Women's Team, reviewed the prison's compliance with Prison Service Policy on detoxification. I am grateful for all three documents. They make a number of recommendations in their reports, all of which I support.

My report makes recommendations for the Prison Service, for the Prison and for Derbyshire Probation Service under five separate headings. One of the recommendations is repeated from a previous death in custody investigation. I am pleased to be able to make three good practice recommendations.

Overall I am satisfied that the care and treatment the woman received was appropriate and compassionate. However, I do have concerns that self-harm warnings were not dealt with appropriately.

Stephen Shaw CBE
Prisons and Probation Ombudsman for England and Wales

June 2005

Summary

1. The woman died on 29 July 2004 some 13 days after being remanded into the custody of HMP New Hall, by South Derby Magistrates' Court, where she had been charged with theft. The court appearance was adjourned until 6 August to allow for further enquiries to be made and to determine the most suitable method of dealing with the case.
2. The clinical review carried out on behalf of the Wakefield PCT makes no recommendations for the prison. It makes two observations under the heading "Commentary and Recommendation".
 - *It was obviously felt that the level of observation possible in the detox unit was sufficient to ensure that any attempt at self-harm would be detected. In consequence no F2052SH was opened, despite the "gesture" which had occurred prior to admission.*
 - *Had a F2052SH been opened, an enhanced level of supervision may have helped prevent her death on the wing five days after the end of detox.*
3. The woman's family have no questions regarding the care and treatment she received whilst in prison and are content to leave the investigation team to assess this on their behalf. Her family were invited to meet with the Governor at the prison, which they did. They described the prison as being supportive at the time of her death and afterwards. The only question to which they would like an answer to is why she decided to end her life. Unfortunately, this is a question to which this report cannot provide an answer.
4. The investigation team found that the prison Chaplaincy Team was viewed by prisoners as very supportive, accessible and caring. A service for the woman was held at a church in Wales, attended by the Governor, Deputy Governor and Chaplain. The Governor has very kindly offered to assist her family with travelling costs in order that they can attend the inquest. This is an excellent gesture.
5. At the time of her death, there had been a total of eight self-inflicted deaths in New Hall since 1 January 2000. Since her death there have been a further two self-inflicted deaths at the prison.

The woman

6. She was born on 31 March 1975 in Wales and aged 29 when she died. She was one of a family of five girls and a boy. She was educated in Wales and left school at the age of 15 years. It was soon after leaving school that she began to offend, which resulted in a number of court appearances and custodial sentences. The majority of her offending history was drug related. She had one son, whom she adored, but had not seen for some time. At the time of her death, her son was living with his natural father.
7. On 16 July 2004, she was remanded into custody on theft charges. It was whilst in the court cells pending her transfer to New Hall that she made an attempt to self-harm by tying a ligature around her neck using her shoe laces. There was no information to suggest that she had made any attempt to self-harm previous to the court cell incident.
8. On her arrival at New Hall, she agreed to join the prison detoxification programme. She was placed on a methadone reduction programme, which she completed five days prior to her death.
9. As she had not been considered by the prison to be at risk of suicide, she was not given the opportunity to sit down with a multi-disciplinary suicide and self-harm team to discuss what had caused her to attempt to harm herself in the court cells.

HMP New Hall

10. New Hall is located at Flockton on the outskirts of Wakefield and was originally used as a satellite prison to HMP Wakefield. In 1961 the role of the prison changed to holding male young offenders and in 1987 it changed again to an all female establishment. It currently holds adult women and young offenders who are either sentenced or remanded into custody by the courts. The Certified Normal Accommodation (CNA) is 367 with an Operational Capacity of 428. The population breakdown at January 2005 was adults 74 per cent, young offenders 11.6 per cent and Juveniles 14.4 per cent.
11. The prison offers a variety of regime activities including offence related courses. It has a well-established detoxification unit, offering support and treatment to those who wish to engage with the programme.
12. In November 2003, the Chief Inspector of Prisons carried out an inspection of the prison and summarised the visit saying:
 - *there is a need for active involvement by community agencies, such as social services, drug treatment providers, employers and housing agencies, to support the work done in the prison.*
 - *like other women's prisons, New Hall is holding women and girls who are seriously mentally ill or with high levels of self harm, linked to substance abuse. There is an urgent need to provide alternative therapeutic environments where appropriate treatment and support can be offered.*
13. In February 2003, a full Standards and Security audit was carried out by the Prison Service. The prison was given a "Good" rating for both Security and Standards and rated at 84 per cent in both areas. The latest Audit carried out in February 2005 assessed the security as 85 per cent, critical baseline standards as 83 per cent and standards audit modules as 71 per cent. The self-audit for Suicide and Self-harm was assessed as 90 per cent.

Investigation Process

14. The investigation team met with the Governor at the prison. The Governor briefed the team and made a number of documents relating to the woman available. She appointed a manager to act as the teams Liaison Officer. The team also met with a member of the Independent Monitoring Board (IMB) and a member of the Prison Officers Association, (POA), to brief them about the investigation.
15. The investigation team viewed the cell that the woman had occupied. In order to familiarise themselves with the wing routines, they spoke to staff employed on the wing.
16. The documents were examined and a list of staff and prisoners identified whom the team would want to interview. The Liaison Officer made the necessary arrangements for the interviews to take place.
17. The investigation team was given additional specialist support regarding suicide prevention and substance misuse from members of the Prison Service Women's Team.
18. The investigation team received full co-operation from staff and prisoners.

Findings

19. On 16 July 2004 the woman, who at the time was of no fixed abode (NFA), was remanded into custody by the South Derbyshire Magistrates' Court on theft charges and allocated to HMP New Hall. A Probation Officer was in court when she was remanded into custody. Her role was to monitor court appearances which may require action by the Probation Service. The Probation Officer made a statement to the police and said that she had noticed the woman becoming depressed when the court heard of her son being taken into care in Wales. The Probation Officer was so concerned at the woman's body language that she suggested to her line manager that the woman should be interviewed immediately. She stated that she had made this suggestion in order to assess the woman for any thought of self-harm and to alert the custody staff.
20. The Probation Officer's line manager gave a statement to the police and stated that he interviewed the woman following his Probation Officer's request. The woman had admitted to him that she had tried to commit suicide in the court cells that day by tying her shoelaces around her neck and that the cell custody officer had found her. She also said on at least two occasions to him, "*I'm going to do it*". He had made an entry on the Probation Case Records and Management System (CRAMS) that she was depressed and withdrawing from heroin. He stated that she was suicidal and that she had removed her shoelaces to tie around her neck. He also said that he had alerted Group 4 (escort company) and HMP New Hall to his concerns. He said that the woman informed him that she had not wanted to be found and that she was concerned at just having her son taken from her and feared she would lose him.
21. The woman was located in the court cells awaiting transfer to prison. The investigation team understand from the police officer dealing with the incident that, due to the level of concern for her safety a 15-minute monitoring watch was commenced by the court staff. This means that she would have been observed at least every 15 minutes.
22. The Senior Probation Officer (SPO) completed the Post-Sentence Interview (PSI) report and the Prison Service Suicide and Self-Harm Warning form alerting the escort company and Prison Service to the fact that she was suicidal. However, he did not make any specific entry onto the warning forms that she was upset at her son being taken away.

Concerns of suicidal or self-harm issues should clearly note the specific information (if known) on the Self-Harm Warning Sheet.

23. The SPO also took the additional precaution of ringing the prison's Probation Office directly and informing them of what had occurred in the cells.

The SPO should be commended for his efforts to alert the establishment to his concerns.

24. The SPO telephoned New Hall Probation Office and spoke to the Probation Administration Assistant. She made a brief note of her conversation which indicates that he had informed her of the child protection issues. She then transferred a summary of the message onto the Head of Custody (HoC) by e mail.
25. Following a previous death in custody, it had been recommended and accepted by the Governor that any information regarding concern of self-harm being received from an outside source required the recipient of the information to carry out specific tasks. The prison Suicide and Self-Harm Policy was updated in October 2003 to reflect this. At page six, paragraphs five and six, the policy says that the person receiving the information should ensure: *(a) the prisoner/trainee location is identified, (b) the Orderly Officer is informed, (c) the relevant Residential Manager is informed, (d) records action taken in telephone log book or wing book.* The investigation team could find no evidence of this having taken place. Paragraph six of the policy instructs *that a review of the information should be made by the Orderly Officer in consultation with other relevant staff and the individual and an assessment made to open form F2052SH and if not then a record to show why the form was not opened.* This procedure was not carried out either.
26. It is unclear why the Probation Administration Assistant did not follow the instructions contained in the Local Suicide and Self-Harm Policy and contact the Orderly Officer. However, the investigation team are satisfied that she made every effort to ensure that relevant staff were informed. In her statement, she said that following the phone call from the SPO she took the information to Reception staff. The investigation team was unable to establish whom the message was passed to and none of the Reception staff interviewed recalled any conversation with the Probation Administration Assistant regarding concerns about the woman.
27. Unfortunately the HoC was not on duty at the time the Probation Administration Assistant sent the e-mail to her. However the HoC confirmed that she opened the e-mail the following day when she returned to duty. She followed up the e-mail that day and was satisfied that the woman had been assessed and that the need to open a F2052SH was not required.
28. Once the Reception staff receive someone into custody they either open a new prison record (F2050 Core Record) for a first time reception or add information to an existing core record. The information would also be entered on the Local Inmate Data System (LIDS), which is a computer system holding the core information on an

individual prisoner. The prisoner is then searched before being interviewed by the Reception screening nurse. The nurse will complete a Cell Sharing Risk Assessment form, which is used to identify anyone likely to harm others and notes any concerns.

29. The Core Record was completed. The woman was given prison number JL8656.
30. In the woman's case the risk assessment form shows at section three that the warning from the Prison Escort Record (PER) and Suicide and Self-Harm Warning sheet written by the SPO had been transferred to the assessment form.
31. Additionally, the Reception Officer also noted the information from the PER form and Self-Harm Warning sheet and made an entry on the reception sheet, underlined in red, "*warning*". It is a matter of concern that, despite clear warnings from the Probation Staff at Court, the policy was not followed by at least five members of staff who initially dealt with the woman at New Hall.

The Governor should ensure that all staff adhere to the local Suicide and Self-Harm Policy regarding information being received from an external source. (Previous Recommendation)

32. The Orderly Officer will, as part of their duties, visit the Reception area and sign the Reception book to show that they have attended. The investigation team were not satisfied that the Orderly Officer would ever be made aware of anyone arriving on a warning form, where a decision had been taken not to open a F2052SH by the Reception staff.

The Orderly Officer should examine the Reception register each evening and satisfy himself/herself that all prisoners received that day with a warning note have been assessed correctly with regard to not opening a F2052SH.

33. The Reception Unit has a Senior Officer as the line manager. The manager appeared to be regularly taken away from the area to support the establishment. The absence of the line manager leaves a void in a vulnerable area in which officers are making decisions without clear leadership.

The Governor should consider re-examining the staffing profiles to ensure that a manager is on duty in the Reception department at all times, when prisoners are likely to be received/discharged.

34. The Reception referral sheet identifies a number of action points, all of which were dealt with by the Healthcare Department. The Reception Urine Testing record indicates that the woman had tested positive for

benzodiazepine, cocaine and cannabis and had agreed to consent to an Opiate Detoxification programme.

35. The investigation team examined the procedure for deciding how a prisoner arriving at the prison and identified as being at risk would be assessed to decide whether to open an F2052SH. Additionally, the team asked what the procedures were for processing a prisoner through Reception. Four Reception Officers were interviewed. The answers given varied from *“it’s the nurse that decides once she has interviewed the prisoner”*, *“an individual can open the document”* and *“it is a group decision following discussion”*, with no clear definitive answer being given. It is clear that some confusion exists within the Reception group as to who has the responsibility.

The Governor should ensure that no single individual has the final say regarding whether to open form F2052SH or not.

36. A nurse interviewed the woman on her initial reception into custody and decided not to open an F2052SH. In her statement, the nurse confirmed that she was aware of the warnings regarding the woman and that she had read and understood the local policy regarding information received from an outside source. She said *that it does not always happen due to the information being received from outside sources being false*. She went on to say *if one was opened on every girl who said they had been depressed in the past, then everyone arriving would have a F2052SH opened*. This view is a cause for concern. She also said *that all those on the “detox” unit were subject to a 30-minute observation check by the wing staff*. The investigation team found that this only applied to the night-time lock up periods, not during the day and applicable to the first 48 hours only. Observation during the day was not so predictable.

37. The investigation team questioned the Reception staff about the Suicide and Self-Harm Warning sheet and asked why it had not been acted upon. A number of staff gave the impression that the escort company over-used the warning notice, *“just to cover their backs”* and *assessed all prisoners as at risk*. We could find no evidence to support this and the Reception records examined clearly showed this not to be the case.

The local suicide and self-harm policy should be republished as a matter of urgency and a retraining programme developed to ensure that all staff are aware of their responsibilities.

38. Prisoners arriving at Reception are processed in stages and are interviewed by up to three different people, including the nurse. However, the available prisoner information about the prisoner may not be available to each officer/nurse when they conduct the interview. Important information may be known to one person but not to the other members of the team.

The Governor should remind Reception staff of the importance of sharing information in order to make informed decisions.

39. Members of Wakefield West Primary Care Trust reviewed the investigation draft report and suggested an additional recommendation regarding the reception process, which I am happy to accept.

The reception process should be more effectively co-ordinated across the multi disciplinary Healthcare team.

40. My investigator met with a Manager from the escort company at Wakefield. The Manager explained that the F2052SH had been withdrawn from the courts and escort agencies and replaced with the Suicide and Self-Harm Warning form. However, it was his belief that the form would be processed in the same way as the F2052SH and that a multi-disciplinary suicide and self-harm team would review the prisoner. He was not aware that the prison did not recognise the new form in the same way as anyone arriving on an open F2052SH. An open F2052SH is the term used by the Prison Service to refer to anyone arriving at an establishment and being monitored under the self-harm procedure.
41. The Suicide Prevention Consultant for the Women's Team was commissioned to carry out a "snapshot" of New Hall's adherence to Prison Service Order 2700 (PSO 2700) Suicide and Self-Harm Prevention. She *identified difficulties within New Hall of communicating prisoners "at risk" and that the prison was not meeting all of the mandatory requirements of Annex "A" of PSO2700.* Her report makes a number of recommendations for the prison. The investigation team concurs with her recommendations.

The Governor should action the recommendations made by the Suicide Prevention Consultant.

42. The Reception officers and nurse were asked about their knowledge of the local suicide and self-harm policy and when they last received training on the subject. It was clear from the answers given that Reception staff had given little attention to it and that training was viewed as optional.

The Reception staff should receive additional training on the local suicide and self-harm policy. The training should be a mandatory annual subject for Reception staff. Suicide and Self-Harm training should be a mandatory requirement for all new officers designated to work in the Reception area.

43. On 17 July, an officer interviewed the woman and completed the Detoxification Wing Compact and the Detoxification Induction form. He did not identify any concerns from the interview.

44. The woman was initially allocated to the Detoxification Unit on a nine day methadone reducing programme. She remained there until 24 July and then moved to E wing, where she shared a cell. On the morning of 29 July, her cellmate was discharged from the prison leaving her on her own.
45. A member of the Prison Service's Women's Team reviewed the prison's compliance with PSO 3550 and concluded that *the woman's withdrawal from drugs was adequately managed in accordance with the agreed women's protocols in place at the time of her reception*. Her report makes eight recommendations and notes that the recommendations are made with a view to improving the care of this very vulnerable, high-risk group of women in prison.

The Governor should action the recommendations made by the Nurse Consultant.

46. A nurse interviewed the woman on her initial reception into New Hall and noted a previous history of depression and arranged for her to be interviewed by the psychiatric services. On 26 July, the Forensic Nurse Consultant interviewed her. Using the Functional Analysis Core Environment (FACE) Risk Assessment Form, he noted on page one a self-harm attempt within the previous week. The identified risk of self-harm was noted on two occasions under the heading of "History" which rated her as "Low Apparent Risk". As she had made a self-harm attempt within the last month the indicator was incorrect and should have been identified as current, as per the instructions.

The Governor should remind clinical staff of the importance of ensuring that the FACE record is completed accurately.

47. Following the interview with the Forensic Nurse Consultant, she was later interviewed by "the In Reach Team" consisting of the CPA Co-ordinator, the Assistant Healthcare Manager and another Clinical Manager (Unidentified). The In Reach Team is commissioned by the West Yorkshire Mental Health Trust to work with patients with severe and enduring mental illness. In his statement, the CPA Co-ordinator said that the purpose of the meeting is to look at the needs and safety of an individual. The current history was available to them and they were aware of the self-strangulation attempt but did not at any stage decide to open form F2052SH. The CPA Co-ordinator said that the meeting does not have a recognised chair and the discussions are not minuted. The woman was not considered as falling within the scope of the team. She was though referred to a Clinical Nurse Specialist (CNS) as identified on page 1 of the FACE document. She did not see the CNS, as she died before an appointment could be obtained.

The FACE assessment meeting should have a recognised chairperson, who is responsible for the agenda, terms of reference and taking a record of the decisions made.

48. A member of the Probation Service met the woman on 27 July at New Hall and informed her that her son would be returning to his father. Her report contains an entry made on 28 July, which described the woman as being low and tearful during the visit. The visit date has been confirmed by the prison as 27 July and not 28. It also indicates that this would be confirmed in writing. The final entry shows that a letter had been typed and placed in the post. The police officer responsible for the case confirmed that he found no evidence to show that the woman or the prison ever received the letter. A copy of the letter has been made available to the investigation team by the police and informs her of the decision to allow her son to remain with his father. It is a matter of concern that the Probation Service did not share with the prison the nature of their visit and the observations about her distress.

The Governor should seek protocols with visiting agencies with the aim of sharing information that is likely to cause distress to a prisoner and to alert the prison to any observations of the prisoner noted during a meeting

49. The Chaplain had arranged for her to be interviewed by Victory Outreach UK, which is an organisation providing Christian homes for young people in need and is based in Gwent, Wales. Her application, written on 29 July, identifies that she wanted to change her life style and live normally. During the morning of 29 July, she was interviewed by a member of the Victory Outreach team and offered a place at a home in Wales on her release. The prison Chaplain described her as being pleased with this outcome.
50. During the day, she had attended the induction programme as planned and spoken to a number of prisoners. Prisoners who knew her well all described her as being normal, bright and bubbly and having no cause of concern for her welfare. Two prisoners suggested that she was being bullied on the wing, but the investigation team found no evidence to support this.
51. At approximately 1:40 pm, she left the wing to attend a pre-arranged group meeting in the Chapel. Instead of going to the group she went to the Healthcare Centre and asked to see the dentist. She insisted that the dentist should remove a tooth, as she was in considerable pain. Toothache is masked by the use of heroin and users of the drug may experience toothache when they stop using the drug. The dentist agreed to her request and extracted one of her teeth. She then left the dental suite and attended the Chapel, where she remained until the evening meal time. The Chaplain confirmed that she had been with her at approximately 4:10 pm and that she had shown no signs of self-harm. On her return to the wing, the Senior Officer responsible for the

unit spoke to her and warned her about her conduct following the incident earlier that afternoon in the Healthcare Centre. She apologised to the manager for her behaviour. A nurse made an entry on her wing history sheet about the inappropriate behaviour in the dental suite.

52. Another prisoner, saw the woman at approximately 4:40 pm. The woman had collected her breakfast pack and a cup of tea. Breakfast packs are issued during the evening meal for prisoners to take for the following morning. The woman had spoken to the prisoner and had said that she was *“going to get her head down”*, as she was still in pain. The wing was then locked up at 5:15 pm.
53. An Officer recalled locking her in her cell after she had collected a meal from the wing servery at approximately 5:10 pm. He then carried out a roll check. He confirmed that she was alive at that stage, as she was eating her meal. He knew her and did not consider that she was at risk when he locked her in her cell. She appeared happy that she had had a tooth removed.
54. At approximately 5:15 pm the Senior Officer was informed by the Officer who had locked the woman up that a television was missing from one of the cells. She immediately took the decision to have each cell searched at 6:00 pm when the evening staff would be back on duty. In her statement, the Senior Officer confirmed that the search began at just after 6:00 pm.
55. The Officer began searching the cells at sometime between 6:00 pm and 6:10 pm. He commenced the search at cell E1 and moved numerically along the wing.
56. At approximately 6:09 he arrived at cell E15 and looked into the room via the observation panel, but was unable to see the woman. He attempted to open the door and was unable to do so, as her body was preventing the door being fully opened. He summoned assistance from another Officer.
57. At 6:09 pm, an Officer, who had possession of the wing radio, sent out a “Code Blue” message to the control room. “Code Blue” is the local procedure for alerting medical staff that assistance is required involving breathing difficulties so that they know which type of emergency equipment that they need to transport to the incident. The Code Blue message obtained the correct response from the medical team. New Hall also uses a different message to alert the medical staff of blood spillage incidents. This is good practice.
58. When the Officer entered the cell he saw that she was face down with a ligature around her neck and suspended horizontally approximately 15 to 18 inches above the ground. Her left arm was through the lower bunk bed head and her legs on the floor towards the cell door. He

used his "*Fish Knife*" to cut the ligature. However, she remained suspended above the ground, as her arm was caught through the bed head. Fish Knives are so called due to the shape of the design and are designed to enable the user to get under the ligature and the action of pushing the knife forward cuts the ligature.

59. At approximately 6:10 pm, the other Officer arrived at the cell and along with first Officer lifted her from the bed head and then laid her on the floor. At the same time, the Senior Officer arrived and began checking for a pulse and was unable to find one. At the same time, the Doctor, who was working in the adjacent wing, was notified of the incident. Due to the very short distance involved, he and his team were at the cell very quickly. The Nurse and two Staff Nurses assisted him.
60. Both the Doctor and the Nurse made handwritten statements following the incident. Additional statements were taken to clarify whether Cardio Pulmonary Resuscitation (CPR) had commenced. The Doctor confirmed that CPR was carried out for approximately 45 minutes, although the Nurse was unable to recall if prison staff had begun the procedure prior to his arrival. The investigation team are satisfied that instructions to undertake CPR had been given by the Orderly Officer to the officers at the scene. They did not have time to begin due to the rapid response of the medical staff and it was the medical team who commenced the CPR.
61. The Control Room Incident Occurrence Sheet shows that medical assistance (Code Blue) was requested at 6:09 pm by an Officer. The ambulance was requested at 6:10 pm and arrived at 6:25 pm. At 7:00 pm, the Orderly Officer (radio call sign Oscar 1) informed the control room that a second ambulance had been requested, as the first one had a puncture.
62. The second ambulance arrived at 7:06 pm and left at 7:24 pm with the woman on board. The final log entry, which does not synchronise with the log timings, shows that death was pronounced at 7:04 pm. In his statement, the Principal Officer confirmed that she was put in the first ambulance at 6:44 pm and the Paramedic pronounced life extinct at 19:04, which concurs with the incident sheet. She was then transferred to the second ambulance at 7:10 pm and left the prison at 7:25 pm. As she had been pronounced as dead at 7:04 pm when she was still within the prison, the police would have preferred her body not to have been removed from the prison until the Coroner's Officer had given his/her authority.

The Governor should develop a clear protocol with the Police and Coroner for the removal of a body from the establishment and insert the instructions into the contingency plans.

63. Following the incident the Governor held a staff debrief meeting with those staff directly involved. The report does not record any findings. It does comment that paramedics are unable to pronounce anyone dead at the scene and that this has to be carried out at the hospital. This is contrary to the incident reports that the Paramedic pronounced life extinct at the scene at 7:04 pm. My investigator discussed this with the police officer dealing with the case and he confirmed that paramedics do have the authority to pronounce life extinct.

The correct protocol for establishing life extinct and the removal of a body needs to be clarified and inserted into the contingency plans.

64. The prison is required to test its own contingency plans by way of a "desk top exercise". Desk top exercises are used to examine the local contingency plans for dealing with a specific incident and aim to replicate a real incident and identify any shortfalls in the procedures. With the exception of "Hostage Incidents", the Prison Service does not specify a mandatory period for the testing of "Death in Custody" contingency plans.

The Prison Service should consider making the testing of the Death in Custody contingency plans a mandatory annual event.

65. The investigation team examined the most recent contingency plan "Desk Top Exercise" report, for a death in custody, carried out in January 2003. The test incident was for a night time event, when minimum staff would be on duty to respond. The report did not identify any failures with the plans, but noted that the Chaplain should be contacted earlier. The plans had not been tested using a multi agency approach. A multi-agency approach would identify any difficulties in making contact with external support such as Police, Ambulance, and Coroner Office.

The Governor should consider testing the plans using a multi-agency approach.

66. In the woman's case, the prison contingency plan incident log and the Deputy Governor's statement identify difficulties contacting the local police and family. This was due to the telephone numbers on the local contingency plans being incorrect. Had a multi-agency approach to testing the contingency plans under "desk top conditions" been carried out, the telephone numbers would have been identified as being wrong.

The Governor should ensure that the contact numbers for the police are updated.

67. The Senior Officer completed a self-harm questionnaire following the incident, which identifies the initial information. The Principal Officer completed the local incident report form.

68. Two Officers accompanied the woman in the ambulance. Once it became evident that she had died both officers asked if they could go with her to the hospital, "*out of politeness*". This was a simple gesture of compassion, at a very difficult time.

The two Officers should be commended for the care and decency shown to the woman.

69. The investigation team asked if the wing had a telephone available for prisoners to use to speak directly to the Samaritans. The team were directed to what an officer called the "*cleaning cupboard*". The telephone was inside a locked room and was indeed the cleaning cupboard. The room did not have a chair and to access the phone meant leaning across a scrubbing machine. The room was extremely untidy, smelly with stale mops and cluttered. On the wall by the side of the phone was a laminated notice "*This call will be monitored*". This is not acceptable.

The Governor should ensure that telephone calls to the Samaritans are not monitored.

70. The matter was brought to the attention of the Deputy Governor who made immediate arrangements for all the Samaritan phones to be checked and any notices removed. The telephones are bright yellow and located in places that would make it readily identifiable to other prisoners that the person using the phone was feeling vulnerable and/or suicidal. The investigation team understands that the yellow telephones are being withdrawn and all areas will have a cordless phone, which can be handed discreetly to a prisoner. I welcome this.

RECOMMENDATIONS

NATIONAL

- The Prison Service should consider making the testing of the Death in Custody contingency plans a mandatory annual event.

LOCAL

1. Reports

- The Governor should action the recommendations made by the Suicide Prevention Consultant from the HMPS Women's Team.
- The Governor should action the recommendations made by the Nurse Consultant, Substance Misuse, HMPS Women's Team.

2. Suicide and Self Harm

- The Governor should ensure that all staff adhere to the local Suicide and Self-Harm Policy regarding information being received from an external source. (Previous Recommendation)
- The Orderly Officer should examine the Reception register each evening and satisfy himself/herself that all prisoners received that day with a warning note have been assessed correctly with regard to not opening a F2052SH.
- The Governor should ensure that no one person has the final say regarding whether to open form F2052SH or not.
- The local suicide and self-harm policy should be republished as a matter of urgency and a retraining programme developed to ensure that all staff are aware of their responsibilities
- The Governor should remind Reception staff of the importance of sharing information in order to make informed decisions.
- The reception process should be more effectively co-ordinated across the multi-disciplinary healthcare team.
- The Reception staff should receive additional training on the local suicide and self harm policy. The training should be a mandatory annual subject for Reception staff. Suicide and self-harm training should be a mandatory requirement for all new officers designated to work in the Reception area.
- The Governor should seek protocols with agencies with the aim of sharing information that is likely to cause distress to a prisoner and to alert the prison to any observations of the prisoner noted during a meeting.

- The Governor should ensure that telephone calls to the Samaritans are not monitored

3. Reception

- The Governor should consider re-examining the staffing profiles to ensure that a manager is on duty in the Reception department at all times, when prisoners are likely to be received/discharged.

4. Healthcare

- The Governor should remind clinical staff of the importance of ensuring that the FACE record is completed accurately.
- The FACE assessment meeting should have a recognised chairperson, who has responsibility for the agenda, terms of reference and taking record of the decisions made.

5. Contingency Plans

- The Governor should develop a clear protocol with the Police and Coroner for the removal of a body from the establishment and insert the instructions into the contingency plans.
- The correct protocol for establishing life extinct and the removal of a body needs to be clarified and inserted into the contingency plans.
- The Prison Service should consider making the testing of the Death in Custody contingency plans a mandatory annual event.
- The Governor should consider testing the plans using a multi-agency approach.
- The Governor should ensure that the contact numbers for the police are updated

FOR DERBYSHIRE PROBATION SERVICE

- Concerns of suicidal or self-harm issues should clearly note the specific information (If known) on the Self-Harm Warning Sheet.

GOOD PRACTICE

- The SPO should be commended for his efforts to alert the establishment to his concerns.

- The two Officers who escorted the woman in the ambulance should be commended for the care and decency shown to her.
- The Prison Service should consider the use of “Code Blue” and “Code Red” nationally