# INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A WOMAN AT HMP STYAL ON 10 MAY 2006

## Report by the Prisons and Probation Ombudsman for England and Wales

## May 2007

This is the report of an investigation into the circumstances of the death of a woman on 10 May 2006 at Wythenshawe Hospital, whilst in the custody of HMP Styal. The woman had been found hanging in her cell. She was 42 years old.

I would like to offer my sincere condolences to her family and those touched by her death. In April 2007, I was pleased to meet personally with the woman's sister and with her lawyer.

The investigation was undertaken by two of my colleagues. Both they and I would like to thank the Governor of Styal and the appointed Liaison Officer for their kindness and cooperation during the course of our inquiries. Styal cares for many prisoners with a history of self harm and we are aware how much the loss of this woman was felt by all the prison's staff.

The woman had arrived at Styal on 1 April 2006. She had been recalled to prison for breaking her licence conditions. Her original offence was arson, which she had said was a suicide attempt. When she was received at Styal, she had self harmed by cutting her neck and wrist in police custody. She was addicted to drugs and had a long history of mental health problems. She self harmed several times while in prison custody.

The woman was only in Styal for 40 days. In that time, she received a great deal of support and care for her many problems. I am impressed by the commitment and compassion shown by staff. However, I have found areas with room for improvement, especially in respect of the the support the mental health in-reach team gave. My report also draws attention to the demands placed upon Styal's management and staff, given the vulnerability of the prisoners for whom they care.
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I make a total of 11 recommendations and highlight two areas of good practice. I was particularly concerned to learn that staff at Styal were not confident in their use of defibrillators. These are literally life-saving machines, and the Prison Service may wish to consider if sufficient discipline and healthcare staff are trained in their use.

All my reports are about the deaths of individuals. However, I am very conscious that this woman was all too representative of the very many damaged and vulnerable women who end up in Styal and the other women's prisons. I played some role in assisting Baroness Corston during her year-long review of women with particular vulnerabilities in the criminal justice system, a review that grew out of public concern about a series of six deaths of women at Styal in a 13 month period in 2002-2003. Much of the focus of the Corston report was on the needs of women with mental health and drug problems and the development of alternative, more therapeutic, more women-centred approaches to their treatment and rehabilitation. The sad death of this woman serves to emphasise the importance of Baroness Corston's findings and recommendations.

**Stephen Shaw CBE**
**Prisons and Probation Ombudsman** **May 2007**

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## SUMMARY

The woman was received into HMP Styal on 1 April 2006. She had been recalled after her release from HMP Buckley Hall in November the previous year as she had not complied with her licence conditions. She had returned to taking drugs after her release. She also had a long history of mental health problems for which she had been treated as an inpatient on many occasions. At the time of her recall, she was under the care of a psychiatrist and a community psychiatric nurse (CPN).

When she arrived at Styal on 1 April, the escort staff had opened a suicide/self harm warning form as she had used a razor to make cuts to her wrist and neck whilst in police custody. On reception at Styal, staff opened an Assessment, Care in Custody and Teamwork (ACCT) document. This is used to help support and supervise those deemed to be at risk of suicide or self harm. The ACCT form was closed on 6 April.

Styal has comprehensive procedures to care for women during their first few days in custody, and the woman's healthcare needs were assessed by a number of professionals. On 3 April, she was seen by a member of the mental health in-reach team who noted the medication that she had been on in the community (this included carbamazepine to treat her depression and act as a mood stabiliser). This was not a formal assessment and, following the meeting, the plan of action was to seek confirmation of her medication from her psychiatrist and refer her to Mental Health Resource Centre to provide support. It is of concern that no decision was taken to refer her to the visiting psychiatrist or to take her onto the psychiatrist's caseload.

The woman wanted to detoxify from methadone, despite advice from staff that it would be better for her to remain on a maintenance programme. The substance misuse team monitored her as she was determined to detoxify from methadone more quickly than NHS guidance recommends. She did this by not taking all of her methadone. Staff from the team discussed this and worked with her.

Staff from the CARATs team – who provide advice and counselling for prisoners with drug problems – also worked with the woman. However, because of her personal struggle to deal with her mental state, her recall, and worries about her daughter's welfare, their work with her was limited.

The woman was well supported by the Mental Health Resource Centre (MHRC) where she received individual support and benefited from a calmer environment. She also visited the CALM centre where she would draw. She was a particularly good artist.

Towards the end of April, as she was further reducing her methadone intake against advice, she started to cause staff concern. She began experiencing mood swings, and could be tearful or aggressive in both her behaviour and demeanour.

On 25 April, staff raised another ACCT form as the woman appeared particularly low in mood and was concerned about her daughter's welfare. The following day, she said she felt able to cope and the ACCT was closed. However, later that evening she made a deep cut to her wrist. She did not inform staff for approximately five

hours. She was then treated by a nurse but did not require treatment at outside hospital. Another ACCT was opened.

Nurses chased up her prescribed medication with her GP. In actual fact, her psychiatrist had responded on 13 April. However, the woman did not receive her carbamazepine until 3 May.

She took her last dose of methadone on 30 April. From the end of April until her death on 10 May, she exhibited mood swings, volatile behaviour and was at times very low. Staff also said that she sometimes behaved very bizarrely in the things she said. Various members of staff told investigators that, throughout this time, they made referrals to the mental health in-reach team.

On 4 May at 9.17pm, the woman was found with a ligature around her neck. Staff helped remove it and a nurse administered oxygen. In the early hours of the following morning, she pressed her cell bell and asked for the nurse. Again she had a ligature around her neck.

On 7 May, she made very deep cuts to her legs. In an attempt to hide them, she covered her legs in plastic bags and put on her jeans. However, she lost a lot of blood and staff intervened. She was taken to outside hospital and returned to Styal later that evening. It was felt that she had made a serious attempt to take her own life.

The following morning, a senior officer from the wing attended the daily senior management team briefing to express her concern about the woman and the lack of support from the mental health in-reach team. The head of healthcare spoke to the team, and a nurse saw the woman that day. The nurse referred her to the visiting psychiatrist and made an appointment for 11 May.

On the morning of 10 May, the woman became aggressive following a misunderstanding about visiting the resource centre. Staff helped calm her down and she went to her cell. When staff went to unlock her for lunch, they found she had barricaded her cell. When they tried to go in, she threw a chair.

As the woman was subject to observations four times an hour, a senior officer and other staff returned to the cell to check if she was okay and remove the barricade. She became aggressive and tried to hit an officer. She was restrained. After attempts to de-escalate the situation, the senior officer decided to relocate her to the Care Support and Reintegration Unit (CSRU). Staff and prisoners described her as “losing it”. She was shouting, swearing and kicking out at staff.

Once the woman was on the CSRU, staff tried to calm her so she could be located in a normal cell. However, she continued shouting and kicking and was located in a special cell with no furniture. She was placed under constant observation for about one and a half hours. After a while, she calmed down and engaged with staff by talking with them. They described her as exhibiting strange behaviour, with her eyes darting around the cell. She said bizarre things, saying she knew she was going to the CSRU that day, and that she could communicate with the dead and hear voices. However, at other times she appeared very lucid.

It took some time to persuade her to move to a normal cell, but eventually she did. Formally, she was subject to four checks per hour. From the time she moved into the normal cell, she stopped talking to staff. She became aggressive and tore her bedding. She sat behind the door of her cell and refused to talk to staff.

When the nurse went to check on her at about 4.15pm, she had blocked the observation panel. The nurse went outside to look through the cell window and saw her hanging from a ligature attached to the window. She called for help and staff entered the cell immediately, cut her down and started resuscitation.

Other staff attended and clinical staff continued resuscitation for approximately 35 minutes until the ambulance arrived. In this time there were repeated calls to the ambulance service. Whilst I commend staff for their efforts, they did not use the defibrillator machine. Staff did not seem confident in its use. I make recommendations regarding this matter.

In the space of six weeks in Styal, many staff were involved with the woman and many worked hard to try and support her. The findings of my investigation should be viewed in the context of the formidable task that faces Styal in caring for very damaged women. I know from this investigation and from other sources of the very good work that is carried out. Nevertheless, there are a number of lessons to be learned from the sad circumstances of this woman's death.

Once the prison learned that the woman had been receiving psychiatric care in the community, she should have been referred to a psychiatrist. I judge that the system for referrals to the mental health in-reach team needs improving. Amongst other recommendations, I also conclude that professionals other than discipline staff need to be reminded of their responsibilities to contribute to ACCT forms and reviews.

## THE INVESTIGATION PROCESS

1. I appointed two of my colleagues to lead the investigation on my behalf. They visited HMP Styal where they met the Governor. On their initial visit, they were given a tour of Styal including the cell where the woman had been found. They met with members of the local committee of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB).

2. Notices were issued to both prisoners and staff inviting anyone who might have information relating to the woman to make themselves known to the inquiry.

3. Along with the lead investigator, one of my family liaison officers visited the woman's sister on different occasions to discuss the investigation and ascertain any particular family concerns and questions about the investigation. A number of issues were raised. The woman's sister was particularly worried about her sister's detoxification and self harm, and she had a number of other questions about the woman's time in Styal including interactions she had with staff and visitors. She was also particularly anxious that a defibrillator was not used in attempts to save her sister. Another area of concern was the delay in which the woman was prescribed her medication, and the time this would have taken to take effect. I have endeavoured to answer the points raised by the woman's sister both within this report and through other communications.

4. The investigation team interviewed prison staff and prisoners, both formally and informally. The team examined the woman's prison record, medical records and a series of prison documents. They also assessed the care that she received against Prison Service standards, orders and policies.

5. A clinical review of the woman's healthcare in custody was undertaken by North Cheshire Primary Care Trust.

## HMP STYAL

6. HMP Styal began life as a children's home in 1898. It was then used to house refugees, before finally opening as a women's prison in 1962. In April 1999, Styal's population increased in size by 60 per cent following the change of role from a training prison to a local prison, and the closure of the women's wing at HMP Risley. Today it has an operational capacity of 455 prisoners.

7. Styal is the only local prison for women covering the North West and North Wales. It holds mainly short term sentenced prisoners and those on remand awaiting trial. The prison also has a small number of prisoners serving indeterminate sentences. Approximately 3,000 women are received through its gates every year.

8. A report by the Social Exclusion Unit, published in 2002, painted a vivid picture of the characteristics of women prisoners. The report found that women prisoners are less likely than men to be located near their homes and that this has negative implications for maintaining family ties. Yet over half the women have dependent children.

9. Along with high unemployment and low educational achievement, women prisoners present with poor physical and mental health. Half of all female prisoners are drug users. Around 15 per cent have received hospital admissions for mental health problems and 37% of all women in prison have previously attempted to take their own lives. In addition, half of all women in prison have experienced domestic violence in their lives and up to one third have been sexually abused.

10. Styal is essentially two prisons within one perimeter. The accommodation is divided into 16 Victorian houses or villas on one side, and the conventional prison block (Waite wing) on the other. The houses provide shared accommodation for sentenced prisoners and are self contained. Waite wing takes prisoners on remand and consists of 12 double cells and 104 singles, 50 of which are currently used as double cells. The prison has a separate Care Support and Reintegration Unit (CSRU), which provides temporary accommodation for prisoners who need to be segregated or are considered too vulnerable to remain in the main prison.

11. Styal's population is an intensely vulnerable one. The complexity of the needs that women bring to Styal creates a pressured environment for both staff and other prisoners. The number of women with drug and alcohol problems, histories of self harm, physical and mental health issues and experiences of sexual abuse, are above the already shocking average for the female prison estate as a whole. Healthcare staff struggle to manage and treat prisoners displaying a range of mental health problems and incidents of self harm. Self harming takes place daily both on Waite wing and in the CSRU. In a recent BBC documentary about life on the CSRU, the Governor referred to Styal as more like a hospital than a prison.

12. Primary Care Trusts are now responsible for physical and mental healthcare both in prisons and on release. By 2004, mental health in-reach teams were operating in all female prisons to assess and treat prisoners referred to them by healthcare staff. A report by HM Chief Inspector of Prisons on Women in Prison commented that, while service provision is in place, in reality in-reach teams only seem to provide treatment for the most mentally ill women in prison. This suggests that women who are just outside this criterion can fall through the mental health in-reach net.

13. Between August 2002-03, Styal experienced six self inflicted deaths. All six women had histories of drug misuse. Five of the six were located on Waite wing, with one woman located in the CSRU. All died within one month of arriving at Styal.

14. I personally investigated the last of these tragedies and reviewed the circumstances of the previous five. My report was first issued in October 2003 and has since been published. During the investigation, I found serious shortfalls in conditions and regime on Waite wing and was critical of the approach to detoxification then in place. I also reported that the Reeman Unit was overstretched and inappropriately used, and recommended an urgent review of mental health provision. Other recommendations included a review of the reception and induction process. However, my report highlighted the high level and dedication of staff in managing some of the most challenging and vulnerable people in the entire prison estate.

15. Since those events, Styal has seen a transformation in reception, first night in custody and induction procedures. There is no longer an inpatient facility in healthcare and the original mental health facility, the Reeman Unit, has closed. A new mental health strategy has been put in place.

16. After a full unannounced inspection of the prison in October 2005, a report by HM Chief Inspector of Prisons, Ms Anne Owers, said:

> *"The changes that had been put in place – the reception, first night and induction procedures, the CALM centre, the new case management strategy and the commitment of staff in the CSRU – showed what could be done. But they also showed the scale of the need, and the inability of the establishment to do more than skim its surface. Further self-inflicted deaths had been prevented: partly due to detoxification and maintenance, partly to measures that physically prevented suicide, such as the use of segregation, force and special cells. But the establishment had insufficient resources to deal with the underlying causes of the prolific self-harm that was still in evidence, or the mental illness and substance use that often underlay it."*

17. Summing up her inspection of Styal, Ms Owers said:

> *"Styal has undoubtedly moved on, and is a safer and better prison than it was; and this is a credit to both managers and staff, who deal daily with a very damaged, and growing, population. But it is as yet unable to meet the needs of that population or of women in the north-west region."*

## KEY FINDINGS

### 1 to 24 April 2006

18. While she was held in police custody, the woman concealed a razor blade and used it to make cuts on her arms and neck. The police doctor dressed the wounds and escort staff opened a suicide/self harm warning form to alert staff at Styal of what had happened.

19. When she arrived at Styal on 1 April, the woman went through the reception centre and then onto the first night centre. She was seen by the doctor who noted that she looked ill, and had a history of self harm, depression and drug abuse. It is not clear from the records what medication she received at this point. Staff conducted a urine test to establish what drugs she had in her system. She tested positive for cocaine, benzodiazepines, methadone and a morphine based substance.

20. Staff opened a document called an Assessment, Care in Custody and Teamwork (ACCT) form. At this time, the woman told staff she did not know why she had been recalled to prison, and she intended to kill herself. She was very upset and tearful. Staff issued her credit for the phone so she could make a call. They told her about the Listener scheme (Listeners are prisoners trained by the Samaritans who can be called upon when a prisoner is in need of extra support). They also made a referral to the mental health in-reach team.

21. The woman kept a diary of sorts. On 1 April, she made an entry saying that she had no idea why she had been recalled to Styal. The following day, she noted that it could be because she had returned late to the hostel one night.

22. On the morning of 2 April, a trained ACCT assessor conducted an assessment with her. The woman told the the assessor she was worried about her possessions at home, and she was concerned about being recalled. The woman also said that if she was made to serve the rest of her sentence she might try to kill herself. Together with the woman, staff devised a care map. This included putting her in touch with probation and her solicitor to find out more about the reasons for her recall.

23. The same day, a nurse undertook a further health screen with her. The woman talked about her history of depression. She said she had been under the care of a psychiatrist outside of prison, and had been admitted to psychiatric hospitals in the past. The woman also provided the name, address and phone number of her GP and community psychiatric nurse (CPN). She gave details of all the medication she was on, including carbamazepine, diazepam, propanolol, zopiclone, methadone and a ventolin inhaler. The woman said she had last taken heroin, benzodiazepines and cocaine on 30 March, and methadone on 31 March. Under the heading "planned action", the nurse wrote that the woman would be referred for a mental health assessment and to the doctor. She also noted that an ACCT was open.

24. On 3 April, whilst still on the first night centre, the woman met with several other professionals to identify her needs. A nurse from the substance misuse team discussed the woman's history of drug use with her. The woman disclosed that she had used drugs intravenously. She said she took heroin, crack cocaine, amphetamines, cannabis and benzodiazepines. She also admitted she had overdosed "accidentally" about 50 times in her life. They discussed how best to deal with her drug problems. The woman wanted to detox from methadone, slowly reducing the dosage weekly. However, the nurse felt that, given her history of drug use and high risk of overdose, it would be better if she was maintained on methadone. They agreed that she would initially have a stabilisation regime on methadone. They would then have another discussion about whether she would go on a reduction programme. The nurse took her blood pressure and pulse, and noted in the medical record that she appeared to be coping well with withdrawal.

25. In her assessment with the CARAT team later the same day, the woman admitted that she liked the rush of overdosing and this concerned her. The CARAT worker devised a plan of the work, including harm minimisation, overdose management and intervention for use of stimulants, structured one to one work and a brief intervention for alcohol. They made an appointment with her to complete a comprehensive substance misuse assessment the following week.

26. The same day, the woman was seen by a nurse from the mental health in-reach team (MHIT). The last serious attempts at self harm were the original offence of arson and cutting into arteries approximately a year previously. The last episode of deliberate self harm was in the police station a few days earlier. The nurse noted in the medical record that the woman said she did not have any suicidal ideation at this time, but was not sure how she would be once she had detoxed from drugs. The woman told the nurse that the community psychiatric service had diagnosed her with personality disorder, drug induced psychosis and possible bi-polar disorder. She said that she was under the care of a psychiatrist and CPN, and told the nurse the medications she was on. The woman also said she could speak to spirits and receive messages for her family via them. The woman said she had previously been detained under the Mental Health Act 1983, in a psychiatric hospital. The nurse also noted that, when the woman had been in Styal previously, she had been on the Reeman Unit which had housed those with more acute psychiatric problems.

27. The nurse noted that the initial plan was to contact the psychiatric hospital for more information about the woman's medication and to refer her to the Mental Health Resource Centre (MHRC) for support.

28. The Mental Health Resource Centre is coordinated by a senior mental health nurse. The aim of the centre is to provide some therapeutic input for as large a number of women as possible. It can be used both for women feeling vulnerable and those with severe mental illness. The staff deliver formalised group work and also a "positive intervention group". The team try to identify the women who have major mental health problems and anybody else who

they feel requires some support. They provide a relaxed environment. Women can also attend and have a bath, and staff can do their hair and nails if they want to. They can make cards for their family. The centre also looks at positive aspects of the women's lives rather than the negative. The senior nurse further explained, *"we'll look at what they're good at, what their strengths are, who their support is, and just give them one to one time if they want."*

29. Although there are more structured programmes and a trained counsellor attends, the centre has a supportive function rather than offering in-depth work. If there were serious concerns, the centre staff would refer women to the MHIT. The woman was not involved in any group work, but continued to use the centre.

30. Another nurse from the MHIT, completed a mental screening form. It documented that the woman suffered periods of psychotic illness and talked to spirits. The assessment concluded with the same action plan as that of the other nurse.

31. The same day, the woman met with a probation officer who made referrals regarding her housing and a further referral to the MHIT. The woman made a note in her diary that she had been told she had been served with an eviction notice from the Approved Premises in which she was living before her recall.

32. The woman started a methadone programme before she moved from the first night centre to Waite wing on 4 April. The nurse in charge of substance misuse at Styal, made a note that the woman did not want to take the 30ml dose of methadone and would rather be maintained on 25 mls. That evening, an officer made a note in the woman's ACCT that she had become aggressive during evening association, as she was unable to make a phone call to her sister on governors' instructions. This was an instruction that covered the whole of the wing, not just specifically to the woman. Later she calmed down.

33. The following day, the woman was seen on the wing by a nurse from the substance misuse team. Although initially undecided, the woman had chosen to reduce her methadone. The nurse discussed this with the senior nurse from the substance misuse team who phoned the MHIT and spoke with a MHIT nurse. They were concerned that the woman had previously suffered from drug induced psychosis and that a period of stability on methadone would be better for her.

34. On 6 April at 9.10am, two senior officers (SO's) from the wing met with the woman to review her ACCT document. The woman was talkative and said that she had no intention of self harming and was coping better. The review notes indicate that the staff ensured she was aware of the different sources of support available and they decided to close the document.

35. At 11.30am, the substance misuse nurse reviewed the woman's methadone with the senior nurse. The woman was adamant she wanted to reduce the methadone by 2mls a week. The woman also told them that she had low

moods when she felt suicidal. When they discovered she was not on an ACCT, the substance misuse nurse phoned the MHRC and spoke a healthcare assistant. The assistant said that the woman was due for an assessment in order to attend the MHRC the following day. The nurse agreed to meet with the woman on 13 April to review the situation. In fact, the woman came to the attention of the substance misuse team sooner.

36. On the same day, the wing nurse saw the woman as she was suffering from abdominal pain which the nurse thought could be due to heroin withdrawal. The nurse noted that she was listed to see the doctor that afternoon. However, my investigators found no notes to indicate that the woman actually saw the doctor.

37. That afternoon, the woman received a visit from her sister. They discussed her recall and her concerns over her property at the hostel.

38. On the afternoon of 7 April, she attended the CALM centre, a day facility with approximately 30 places for women located on Waite wing. The centre is a caring environment away from the residential parts of the prison. It also has a separate room, equipped with sensory lighting, which provides a relaxing environment.

39. Also on 7 April, the senior mental health nurse assessed the woman for the Mental Health Resource Centre. The senior mental health nurse noted that the woman was known to the team, and would be given regular appointments to attend the resource centre. The woman told the senior mental health nurse that she used self harm as a coping mechanism. The senior mental health nurse noted that the woman had said she heard voices from the washing machine and she had suffered from drug induced psychosis. The woman mentioned that she had been on carbamazepine as a mood stabiliser. The senior mental health nurse concluded that the woman would be seen for one to one sessions and a group session in the resource centre weekly.

40. On 9 April, the woman left 3mls of methadone instead of taking the full dose. On 10 April, she left 6ml. The nurse who issued the medications informed the substance misuse team, and again the substance misuse nurse discussed this with the woman. The woman said that she wanted to be on 22mls and that she could cope on that amount. The nurse noted that there were no visible signs of withdrawal. However, she also noted in the medical record that the woman seemed depressed and low in mood. The woman had told her that she would like to get off the wing for a while to “take her mind off things”. The nurse noted that she had seen “in-reach” on Friday. By this, she actually meant that the woman had been to the resource centre. The woman was determined she wanted to detox quicker than the nurses were advising. They noted that there were no visible signs of withdrawal. She also said she wanted to be maintained on Valium as she relied on it to cope.

41. On 11 April, a mental health nurse based on Waite wing, contacted the substance misuse team saying that the woman did not want to be maintained

on methadone. The senior nurse from the substance misuse team agreed that the woman could undergo a methadone reduction programme.

42. That day, the woman was seen by a CARAT worker, who intended to complete the Complete Substance Misuse Assessment (CSMA). He was unable to do so as the woman was too distressed. He told my investigators that she was crying. She was concerned about her daughter. She was also concerned about her recall to prison and how long she might have to be there. The woman told him that she had binged on heroin before returning to prison and did not feel she was functioning properly. He made another appointment to see her the following week. He also contacted an outside agency based in the community, who offered to visit the woman to explain the reasons for her recall in person.

43. On 13 April, the healthcare centre received a fax from the psychiatric hospital about the treatment the woman had received in February. The hospital said the woman felt she was communicating with the dead telepathically, and this seemed to happen more when she was stressed. The woman also talked of voices in her head, but the psychiatrist did not think she was schizophrenic. He confirmed that she was given 20 mg methadone and 15mg diazepam daily. She was also given carbamazepine 800mg at night to treat her manic depression and mania symptoms, zopiclone - a sleeping tablet/sedative - 7.5mg at night, and propranolol, a drug to reduce anxiety. He further noted she was due for a review on 15 June. There is no note relating to the fax in the medical record, and it would appear that no immediate action was taken on receipt of the information.

44. On 19 April, the woman tried to contact her daughter by phoning a friend to ask if she could speak to her daughter at his house. She tried calling later in the day as well.

45. The same day, the CARAT worker saw the woman to conduct the complete substance misuse assessment. He told my investigators that she was like a completely different person. She was calm, cheerful, and quite jovial and told him that she wanted to be drug free. The woman said she used drugs to help her deal with issues from her past. She had started taking diazepam when she was about 12 years old, then alcohol from 14, and cannabis and amphetamines from 15. She started using heroin when she was 28 years old, but only started using it intravenously aged 32 after her children were removed from her care. The woman said that her self harm thoughts were worse when she was taking drugs. She also talked of her interests and skills. He noted that the woman was clearly artistic, enjoying drawing, writing and playing the guitar.

46. The woman also told the CARAT worker she had been sectioned quite a few times for psychotic behaviour. She admitted she had self harmed, including cutting her arms, legs, stomach, throat, and head, and had also tried to hang herself.

47. He completed a drug dependency scale. She scored eleven (a score over seven is likely to indicate a high level of dependence). He said it was quite difficult to keep her specifically focussed on matters concerning drug use as there were lots of inter-related issues.

48. The CARAT worker was able to tell her that he had spoken to the outside agency and that they were prepared to come and discuss the reasons behind her recall. His understanding was that she had been recalled largely for the safety of herself and others. She was using drugs chaotically and considering suicide. She was missing appointments and generally being uncooperative and unpredictable.

49. The following day, the CARAT worker again contacted the outside agency and they agreed to make an appointment through legal visits to see the woman.

50. A SO also spoke with the woman as a follow up from the closure of her ACCT form. She told him that she was in a good mood at the time. She was engaged with mental health and talking to her family. The woman said if she was concerned again she would speak to staff.

51. The same day, 20 April, The substance misuse nurse spoke to the woman as she was concerned that she was detoxing herself quicker than recommended. The woman said that she wanted to reduce by 2mls every three days until completion. The woman agreed to take the following amounts of methadone:

    21-22 April – 12mls
    23-25 April – 10mls
    26-28 April – 8mls.

52. The doctor saw her on 21 April and echoed the concerns of the substance misuse nurse about the woman reducing her methadone too quickly. The Department of Health guidelines recommend a maximum reduction rate of 5mls per week.

53. Later that day, the woman made several phone calls. The first was to her sister, and they discussed arranging a visit. The woman told her sister that she had been told by the CARAT worker that they recalled her as they thought she would re-offend as her head "was in bits". She also made two other calls to friends. In one, she told her friend that she did not think she had done anything wrong and would be appealing against her recall, and that she hated it in prison. In the other, she called another friend's house where she was able to speak to her daughter. The woman told her daughter that she thought she would have to stay at Styal until January 2007, but she had spoken to a Listener as she had been upset and she could be out in as little as five weeks. The woman told her daughter she was expecting her to visit soon. She told her about a dream she had:

    *"Remember when I dreamt you were in jail, a couple of days later you were. Well I had a dream you were back and banging on my door. I had died and*

*I met God and mother and everything. Remember to ask to come to the wing when you come in to be with your mother".*

54. On 21 April, the woman was meant to take 17ml of methadone but only took 9mls and refused the other 8mls.

55. On 24 April, the woman underwent a resettlement assessment. She told staff that her mental health issues prevented her from gaining employment and that she was on a methadone reduction programme. A basic skills assessment was completed which she passed. She said that she had lost her home and wanted help with accommodation on release. She said that she suffered from depression and anxiety and that healthcare knew this. She again gave a history of substance misuse, and how she lacked confidence to work with people she did not know. Referrals were made for her to attend an A to Z programme, NACRO for housing, Job Centre plus and education. None of these were acted upon before she died. She also attended the CALM centre on this day. She took 12mls of methadone.

**25 April to 6 May 2006**

56. On 25 April, the woman took 10mls of her prescribed methadone dose of 17 mls. The substance misuse nurse spoke with her about this. The woman said she wanted to withdraw at the rate of 1ml per day, and once she reached 4mls she would like symptomatic relief only. She was not suffering any obvious withdrawal signs.

57. That evening, the woman was upset. She was low in mood and very concerned about the welfare of her daughter. She told staff she feared that an officer might open her cell door to find her dead. The woman said she was not taking the correct medication to stabilise her mood, and had been asking to see MHIT for some time but no one had seen her as yet. An officer opened a new ACCT form. The officer noted that they would ask the wing based mental health nurse to see her the following morning. Staff considered how best to care for her, and said there were concerns over her sharing a cell so kept her on normal location. They agreed to check on her hourly. Staff made a note in the wing observation saying, "ACCT opened as she said she is going to cut her arm and body and not inform staff."

58. The next morning, she took 12mls of methadone. In the afternoon, she went to the CALM centre before attending her ACCT assessment and review with the second senior officer and a prison officer. During the assessment, the woman told the SO that she was concerned about her daughter. She told him she had not self harmed since being recalled to Styal, but had made many attempts to kill herself in the past. The woman told the SO she found it difficult getting through the night and had trouble eating. However, she said she had no current thoughts of suicide and was close to members of her family. She was concerned that she did not know her release date. The two staff and the woman discussed her main concern that her daughter would join her in prison. The SO told my investigators that the woman said she felt a lot better than she had done previously. The woman did not want the ACCT form to be opened.

She said she was fine, she was talkative, held good eye contact and did not present herself as being a high risk of self harm.

59. Although she had a long history of self harm, she told the second SO she felt she was able to control it. The SO noted*; "Appears high in mood, talkative and has asked for doc to be closed on understanding she will speak to staff if feels low. Panel agree and deem it closed."*

60. Around midnight, the woman made a deep cut in her wrist close to the artery and lost quite a lot of blood. She did not tell staff for several hours. Once she alerted staff, they called a nurse who came to see the woman at 5.15am. The nurse (whose signature could not be identified in the clinical record) noted that the cut was very deep in the woman's left lower arm, and she was not sure how much blood had been lost. The nurse commented that the woman was very low in mood and had said that she should be on carbamazepine. The nurse steristripped the wound and applied a dry dressing.

61. Another ACCT was opened by a wing officer. He found her low in mood and it took a lot of effort for her to talk to staff. The woman was apparently not interested in doing anything to take her mind off her problems. She was also concerned that she was not getting the medication she needed, that she did not know when she would be leaving prison, and was not sure if she could cope in an Approved Premises again.

62. The officer concluded that, until a full ACCT assessment could be made, the woman should be checked hourly. She should however remain in a single cell, as she was considered a high risk of sharing a cell with others. The officer concluded that a phone and Listeners should be made available at all times upon request. He noted that triggers for her included when she had nothing to do, when she was not mixing and speaking with others, and when she refused meals. (Given the close proximity to the previous ACCT, it would have made sense to have kept the previous ACCT form open. This would have provided greater evidence of the woman's unpredictability. However, the decision to open a new one was perfectly legitimate.)

63. That morning, the woman underwent a further ACCT assessment with a second assessor. The assessor recorded that the woman said she could not cope with coming into prison and not knowing why she was there. The woman admitted that she cut her wrist in a bid to die, but was actually glad she woke up as she knew she needed to be there for her daughter. The woman said she wanted to use prison to get off drugs. The assessor made the following entry in the ACCT: "She is very low and has cut in that way before. Dressed wound herself in towel and plastic bag to conceal blood from sheets. She has cut herself many times before and has depression. Blames herself for daughter … and is aware of 'safe cutting'. Currently 'losing it' and has asked to see Dr about meds and for things to do to keep busy day and night. States doesn't want to be dead at moment but is scared of what she might do to herself. Has been worse than this before. Reasons for living including daughter and son. Wants to prove to them she can be drug free. She asks SO for phone call to her daughter. Agrees to find things to do."

64. Following the assessment, the SO noted that the woman had felt better after speaking with a Listener and the wing mental health nurse. The SO mentioned that the woman had been referred to the MHIT, and marked the urgent referral box. The SO said that the woman talked a great deal about her daughter and was proud of her. The woman had also said she wanted to further reduce her methadone to nil. The SO concluded that the ACCT should remain open, with observations at least hourly due to the woman's unpredictable behaviour.

65. The wing mental health nurse saw the woman the next morning. She described her cuts in the medical records, as a "good attempt". The woman told her she should be on other medication. The nurse tried to contact the woman's GP but the GP was not available as it was lunch time. She passed this onto the staff at the mental health resource centre to follow up as she was due to go off duty. The nurse also referred the woman to the MHIT.

66. The woman was monitored at least hourly throughout the day. She took 10mg of methadone and attended the CALM centre. At 3.45pm, the senior nurse from the MHRC requested a copy of the medication that the woman had been on from her GP in the community. That evening, during one of the checks, a prison officer noted that the woman was looking through her paperwork and was quite tearful. She was also given a 'detox pack' in the evening. (A detox pack consists of two bread buns, hot chocolate and jam, to allow the women to have something to eat during the night.) The woman noted in her diary that she was in pain. She also recorded that her recall papers had been sent.

67. In the early hours of 28 April, the woman was awake and shouting at times. The ongoing record in her ACCT form states that she kept blocking the observation panel in her door. Staff either had to remove the obstruction or persuade her to move it. She was also feeling quite paranoid and told staff that they were all against her. She was noted to be asleep by 3.00am.

68. In the morning she took 10mg of methadone. The woman again noted in her diary that she was in some pain. She went to the MHRC where the senior nurse noted in the clinical record that the woman was experiencing some paranoid ideation, and that some pressure of speech was observed. The woman responded well to therapeutic intervention and one to one time. In the afternoon, she attended the CALM centre. In the evening, she went out on the wing on association, and staff noted in her ACCT form that she was interacting well with others. However, when she was asked to return to her cell, she became angry and threatening as she had not had her medication. She threw her cup of hot water in the sink, and it splashed another prisoner in the face and they began to argue. Nevertheless, once she had her medication, she began to calm down.

69. The following day, 29 April, she attended the CALM centre again. She took 9 ml of methadone and made a note in her diary that she was still in pain. Throughout the day staff checked on her. They noted in her ACCT that she had been a bit "hyper" and lively on the wing but then seemed to settle. She

came out on association and was also observed watching her television. A wing officer had a lengthy talk with her. The officer recorded that her mood was very up and down: “Talks calmly, then gets upset and tearful, then talks calmly again.”

70. On 30 April, the woman took 8ml of methadone. She made a note in her diary that this would be her last dose and that she was experiencing pain. After this, she did not collect any further methadone. She told staff she was withdrawing but that she was determined to come off the methadone. According to her ACCT, staff checked her regularly and she expressed no problems or concerns. She appeared calm.

71. The woman was monitored throughout the night. She came out on association in the morning but refused her methadone. The woman did not eat her lunch but told staff she was okay. She again refused to take her medication that evening. She noted in her diary that she was in pain, sweating and freezing.

72. On 2 May, the woman filled out a visits booking form for some friends and her sister to visit. She again refused to take her medication. She made a note in her diary saying she was sweating and freezing again. She asked to see the nurse. The wing mental health nurse saw her and made a note in her medical record that she had lost weight and was experiencing pains in her legs. The woman said her veins were sore from where she used to inject. The nurse noted that the woman had stopped her methadone at 9mls, but was feeling okay apart from getting cramps. The nurse sent a prescription for the doctor to sign for quinine sulphate, a medication used during detoxification to stop cramps. The nurse also noted in the medical record that she had phoned the MHIT about the woman.

73. During interview, the wing mental health nurse told my investigators that she had become increasingly concerned about the woman and the thoughts she was having. The nurse said that the woman was good at putting on a front sometimes, but she knew she was getting worse. The nurse told investigators she had put in two referrals to the MHIT and had also made a number of phone calls saying how concerned she was. She said that, on one occasion she called, she found there were no staff from MHIT in the prison.

74. That afternoon, staff had to encourage the woman to come out for exercise. She told staff that she was feeling close to death and had pains in her liver. She said she had a dream about going to heaven and felt this might be significant.

75. On 3 May, the worker from the CARAT team again met with the woman. She told him she had stopped taking her methadone three days previously and was “made up” about it. He described her as upbeat and with a good sense of humour. He told her that staff from the outside agency would be visiting the coming Friday to explain why she had been recalled to prison. He told my investigators he thought the woman was pleased that she was going to be meeting with the officer, but also a little anxious about it. She also saw the

prison doctor. The entry is difficult to read, but the woman insisted she had been on carbamazepine. The doctor prescribed 400mgs twice daily of carbamazepine. The doctor also noted that she had lost weight and prescribed some food supplements. The woman noted in her diary that "news did me in, even worse sweating". It is not clear what news she was talking about.

76. On 4 May, she told staff she had been "rattling" all night. Staff noted in her ACCT that she went to "in-reach" in the morning. There are no notes to evidence that she saw anyone from the MHIT. This entry may refer to her attending the MHRC. That afternoon, the woman attended the CALM centre. Apart from saying she was concerned about her daughter, she did not present any concerns.

77. The substance misuse nurse conducted an unplanned review after being approached by the woman on the wing. The woman said she had stopped taking methadone of her own choice once she had reached 8mls. She told the nurse that she was in a lot of pain. The nurse noted in the medical record that she passed this information onto the healthcare staff, and told the woman of her concern that she was not compliant with the detoxification regime.

78. On the same day, a SO met with the woman to complete the care map in the ACCT form. This should have been completed at the initial review. The SO noticed that it had not been completed, so met with the woman to discuss it. The SO said that she had not had a great deal of interaction with the woman prior to this, and they had quite a long talk. The woman was chatty and friendly, but raised a number of issues. The SO noted that the woman's time needed to be occupied to distract her from thoughts of suicide. She was having problems with her medication and seeing her recall paperwork. The SO agreed to speak to probation about the woman's parole paperwork and the wing mental health nurse agreed to look into the woman's medication issue. The SO said that the woman had already been referred to the MHIT, so it was a case of waiting for them to assess her.

79. That evening at 9.17pm, a second prison officer went to check on the woman but could not see her and got no response when she was called. Staff entered the cell to find her in the toilet cubicle with a bed sheet around her neck. They helped her remove it and a nurse attended. An F213SH self harm form was completed which outlined what happened. It said that oxygen was given to her. There is no corresponding entry in the the woman's medical record about this incident. Staff checked on her throughout the night and when they got no response they went into her cell.

80. At 2.30am on 5 May, it was noted in the ACCT record that the woman pressed her cell bell and asked to see the nurse. The third officer noticed that she had a ligature round her neck. There is no record to say what happened as a result. Staff noted that an F213SH form was completed, although this could not be located at the time of the investigation.

81. Later in the day, the woman was taken to the visits room. She believed she was due to see the outside agency about her recall. However, the representative was on leave and had forgotten to cancel the visit. The CARAT worker left a message asking him to contact him as soon as he returned. The woman was obviously annoyed and shouted at another prisoner. When back on the wing, the woman made an application to the probation department, saying she had seen someone from probation the previous week and had been given her recall paperwork. She had posted it to her solicitor but it had not yet been received. Probation confirmed the paperwork had been requested by the woman's solicitor on 2 May and sent on 5 May.

82. The CARAT worker went to Waite wing to let the woman know that he had made calls to the outside agency. However, he could not speak to her as, when he arrived, she was being escorted off the wing in what he described as "mental health services" (it is possible he meant the MHRC). He told investigators that she was hysterical and crying. She was saying something about reading that a paedophile had been released from prison and she did not know where her daughter was. He did not try to speak with her as she was too upset.

83. It is noted in the ACCT that, when the woman was unlocked that afternoon for her medication, she was very hostile and shouting. She was saying that the hostel had "stitched her up". She made a note in her diary, "no sweating – made up. Visit from the outside agency, never turned up." Throughout the afternoon, she blocked her observation panel, but spoke to staff when they checked her. She was given her mail and opened a letter. She was also given a detoxification pack. She was tired and slept through the night.

84. The following day, 6 May, she went to the CALM centre. At 6.30pm, a prison officer made an entry in the woman's ACCT noting that she was very paranoid and believed she was in the corner room on the wing as a punishment. The officer explained that the woman was in the corner room as she had been assessed as a "high risk cell share", meaning she was considered a risk to others in a cell sharing situation. There are a limited number of single cells on Waite wing, and the single cells are at the bottom of the landing and it was happenstance that she was located in the one in the corner. The woman also believed that an officer had stolen her clothes to "mess with her head" and accused staff of throwing her mail in the bin. The officer commented that the woman was exhibiting "very bizarre behaviour". She said the woman was screaming and difficult to calm down.

85. At some point on 6 May, the woman made her last diary entry. She wrote "No dinner- meds. Sneezing all day, sore throat. WANT TO DIE." During the evening, staff noted in her ACCT form that she appeared low and un-interested.

**7 to 9 May 2006**

86. On 7 May at 11.00am, an officer noted that the woman was sitting on her bed and appeared very withdrawn, but that there was no evidence of self harm. Staff recalled that she had not come out of her cell that morning. A SO said that she was acting strangely. On several occasions, she pressed her cell bell and when staff arrived she was abusive to them. However, she seemed withdrawn and did not look well. When staff unlocked her cell for her to collect her lunch, she did not acknowledge them. An officer told my investigators he went in to check on her along with another officer. They asked her if she was okay, but she only murmured back and they could not decipher what she was saying. They called for a nurse to check on her.

87. The nurse came and took her temperature and general observations. Her pulse was steady and her colour was good. Although she would not open her eyes, the nurse was not concerned at that point. The officers went off duty for lunch and asked the staff on lunch patrol to keep a closer eye on her as she had been so withdrawn. The SO said she asked the patrol staff to check on her every ten minutes.

88. At approximately 1.30pm, staff found that the woman was slumped on the floor and seemed almost unconscious. The alarm bell was pressed and the SO attended. She said there was a huge amount of blood. She remembers the woman saying something like “30 tablets”.

89. A nurse received an urgent call to the woman’s cell and was there within seconds. When she arrived, the woman was semi conscious with a bag full of blood, but the nurse could not find where the blood was coming from. Another nurse arrived and together the two nurses assessed her. They found that her blood pressure and observations were very poor. The nurse thought the woman might have taken something as her observations were so poor. She ordered a blue light ambulance. One nurse was supporting the woman’s upper body, continuing with the observations and administering oxygen. Staff lifted her legs and a nurse saw on one of her calves two lacerations which were between one and two inches thick.

90. A nurse bandaged the woman’s leg. She described her condition as causing her great concern and potentially life threatening. The ambulance arrived promptly and took her to Wythenshawe Hospital.

91. There is some confusion surrounding whether the woman took any unprescribed medication on that day. Given her presentation, the nursing staff thought it was possible. Some officers thought she mentioned it herself, but she was disorientated. A prisoner told an officer she thought the woman had been trading medication, which she believed to be zopiclone, for tobacco. The officer contacted the hospital to let them know of the possibility and also submitted a security incident report. The woman denied that she had taken medication. There was no evidence to suggest that she had been taking unprescribed medication in the toxicology report after her death.

92. The SO told my investigators the major concern was that, not only had the woman made deep cuts to her leg, she then wrapped her leg in a plastic bag before putting her jeans on. The SO felt the reason for this was to hide the self harm from staff, and considered this to be a very serious self harm attempt that could have led to her death. When a nurse wrote in the woman's medical record, she noticed an entry from another nurse from a couple of days previously that mentioned the woman being low in mood. The nurse put the woman on the list to see the doctor the following day.

93. Two officers escorted the woman to the hospital and stayed with her. One officer told investigators that initially the woman was quite drowsy, but this was due to her blood pressure being low. Once they arrived at hospital and she was being treated, she seemed brighter. The officer described her as having a dry wit, and said she made a few jokes and was generally quite good humoured whilst they were in the hospital. She told my investigators that the woman had been apprehensive about them treating her cut as it was painful. At one point, she became agitated and said, "I don't want to lash out at you, but you're hurting me." The officer described her as chatty and lucid. She did not want to stay in hospital and she berated herself for doing it. She was concerned she had "put people out". The woman was pleased to be discharged, as initially it looked as if she would be admitted overnight. The officer recalled the doctor saying that her blood pressure had returned to normal and her blood tests had come back normal. The woman had maintained that she had not taken any medication. The officer did not think that she had intended to die, and found her quite positive, talking about the future and her daughter.

94. There was some confusion from staff as to whether she discharged herself from hospital or whether the hospital said she could leave. A nurse phoned Wythenshawe for more information, but no one was obtainable. One of the officers who escorted the woman contacted Styal at 7.30pm to say that the woman was still in pain, but dressings for her wound had calmed her. They were waiting for her blood pressure to rise and would then discharge her. Therefore it seems she was discharged by the doctors at the hospital.

95. The woman returned to Styal that evening. Initially, she was quiet when she returned. Staff moved her to the safer cell (a cell with no obvious ligature points) on the wing and increased her observations to four an hour. A SO noted that a nurse spoke with her and told her they were going to put a referral in to the MHIT. There is no corresponding entry in the clinical record.

96. A case review was conducted the same evening at 8.45pm. The woman attended with the duty SO and two officers. The woman was assessed as being at high risk of self harm. The main concern was that she had attempted to conceal her cut and the blood to prevent staff from noticing and therefore helping her. She also said she had planned to do it the night before but decided to wait a day. A note was made that a referral was made to the MHIT as an emergency, and her observations increased to four per hour day and night.

97. Staff checked on her throughout the night. She became very aggressive and angry at being in the safer cell. She told staff that she had ligatures in the cell. Staff went into her cell at 2.30am but she appeared asleep and there was no evidence of self harm. By 3.00am, she was awake and remained so for most of the night. She kept telling staff to go away. At 7am, she asked to see the nurse for steristrips for her leg. It is reported in the ACCT that a nurse attended and spoke with her. By 8.30am, she was complaining that she wanted to move back to her cell. At 9am, the senior substance misuse nurse saw her in passing and the woman said she was in pain. The senior nurse said she would arrange to see her later in the week.

98. Every morning at Styal, there is a brief management meeting attended by the senior managers. On 8 May, a SO attended to express the concerns she and other wing staff had about her. She told senior managers what had happened during the previous day and repeated officers' concerns about her attempts at hiding her serious self harm. The SO said it was exceptional for her to attend the morning meetings; she had only been about five times in the year. The head of healthcare was also at the meeting and said that she would ask the MHIT to make an urgent assessment of the woman that day.

99. At 11am, the woman moved back to her cell on Y side of Waite wing. An officer remembered that the woman was quiet but had complained of stomach pains. She reassured her that she was down to see the doctor that afternoon. At midday, a nurse saw her to dress her wound. The woman told her she had stomach pains, and the nurse reassured her by saying that she would see the doctor that afternoon. The woman was tearful.

100. The nurse recalled seeing the woman in the healthcare centre waiting to see the doctor. She asked her if she was okay, and she replied "no". The woman saw the doctor who checked the steristrips. The woman was not offered a bandage due to the risk of her using it as a ligature.

101. A note was made in the clinical record that she said her severe abdominal pains had been treated at hospital with blood tests and x rays. The woman reported that she discharged herself despite the hospital wanting to keep her in, although this was not the recollection of the escorting officers. The entry noted that she was "pale, emotional and agitated. Rambling talk. Very thin, visible peristalsis. Says tender all over." Someone spoke to the hospital at 4.40pm and was told they would get the results and ring the prison later in the day. It was not possible to identify the signature in the clinical notes. There was no evidence of the results or any indication as to what their conclusions were and what action was required. It is clear that information as to the treatment she received and any implications for her future care should have been given to staff on the same or following day that she was discharged from hospital.

102. At 3.30pm, she was seen by a senior mental health nurse. The woman told her that she was embarrassed by her self harm but did it as she had not felt listened to. She said she felt safe now. The woman admitted that she was not eating, but promised to have an evening meal. They agreed that a full

mental health assessment would be conducted the following day. The senior nurse referred her to see the visiting psychiatrist on 11 May.

103. At some point on 8 May, the outsde agency contacted the CARAT worker to apologise for not visiting the woman as they had arranged and to make another appointment. The CARAT worker went to tell the woman but she was with the MHIT.

104. That evening she came out on association and told staff she felt a bit better. Another prisoner told an officer that the woman had said that, if she had known how to kill herself the previous day, then she would have. The officer made a note in the ACCT. The woman received her post late at 10.00pm and said, “at least someone is writing to me.” She was not given her medication until 11.00pm.

105. The woman was checked throughout the night and appeared to have been peaceful. On 9 May, she attended the MHRC and had a one to one with a healthcare assistant. The woman told the healthcare assistant about her self harm, saying that staff said she had behaved badly and deserved punishing. They also discussed her eating. She believed her daughter would be coming into prison but at the moment her daughter was missing. The healthcare assistant said that the woman was painfully thin and it was obvious she had lost weight. She explained to investigators that the woman had been saving food for her daughter. The woman felt that her daughter would be pleased when she saw the food, and she explained that she had nothing else she could give. The woman told her that nurses on the wing had been encouraging her to eat, and she had eaten some small amounts. The healthcare assistant also noted that the woman’s breathing was quite shallow.

106. Whilst the woman was with the healthcare assistant, the senior mental health nurse spoke with the senior nurse from the MHRC. They agreed that the senior mental health nurse would not conduct a full mental health assessment as the woman was well known to staff from the MHRC and was receiving input from them. The MHRC senior nurse agreed to keep the senior mental health nurse up to date with any progress, and to await the outcome from the woman’s appointment with the psychiatrist on 11 May.

107. Staff reported that the woman appeared happier and calmer. She was smiling and chatting with other prisoners throughout the day. A Sister, part of the chaplaincy team, made a pastoral visit to Waite wing. The woman approached her and said “remember me?” The Sister remembered her from a previous time in Styal and agreed to return to see her once she had spoken to some other prisoners. Later, the sister and the woman spoke together. The Sister told my investigators that she spoke with her about the hymn, The Lord is my Shepherd. The woman’s mood changed, and she explained that the hymn held bad memories for her. At this point, the woman ended the conversation and went back to her cell saying she wanted to be alone. The Sister remembers an officer going to her cell door shortly afterwards and that the woman was singing a hymn. She recalled that the officer’s presence seemed to further aggravate the woman.

108. An officer noted in her ACCT that the woman spent some time preparing food and watching television in her cell. The woman did not want to go outside for exercise, but came out of her cell for association. The officer remembered her singing hymns, and she had laughed about it saying it reminded her of being at school. Another officer told my investigators that she remembered speaking with her on the evening of 9 May while she was supervising the issuing of medication. The woman was saying her head was itchy and she thought she might have lice. They had a conversation about it and the officer said she should mention it to healthcare. Again, she was checked throughout the night. She spoke to staff on occasion but was noted to be asleep when checked from 1.00am till 5.00am.

**10 May 2006**

109. At 7.00am on 10 May, a nurse went to see the woman. They sat on her bed talking for about 20 minutes. The nurse recalled that her room was always exceptionally tidy and organised. She said that the woman looked pale and emaciated. The nurse had been concerned about her since she had cut her leg on 7 May. She said she felt that she should have had a blood transfusion or at least iron tablets, and therefore put her down to see the doctor. The woman told the nurse that she had had a dream in which a group of people were going to die in a cult. Her father had been in the dream telling her he did not believe in God, and she had found this upsetting. The woman again talked about missing her daughter, and being concerned that she did not know exactly where she was. On a previous occasion, the nurse had told her of a memory she had of her own daughter giving her flowers when she was only three years old. The woman gave her a picture of a young child giving her mother flowers. This had touched the nurse. When she left the woman's cell, she remembers saying "see you tonight" and the woman replying "yes, see you tonight."

110. At 9.15am, the woman spoke to an officer about wanting to attend the MHRC. At this point, she was calm. She told him that her leg was sore, and she was sorry that staff had had to deal with all the blood when she had cut herself.

111. The officer checked the list for the MHRC and noticed the woman's name was not on the list. He knew that she often went to the centre and he added her name to the list. Ordinarily there is an Operational Support Grade (OSG) on duty to coordinate movements on and off the wing and escort the women to their different activities. However, on that day there was no OSG on duty and another member of staff took on the responsibility. The officer had actually put her name on a copy of the movements list, not the original, and the woman was not called to the MHRC. She asked him about this. The SO heard the conversation, and said that she had an appointment at 10.45 that morning. The woman was accepting of this. However, there were two women on the unit with the same surname. Staff said both were similar in the way they talked and the appointment was in fact for the other women.

112. The woman reacted badly to this. She became agitated and verbally aggressive towards the officer. The SO approached her and apologised for the confusion. The SO managed to de-escalate the situation and walked back with her to her cell. The woman was upset that she could not go to the MHRC and get off the wing, but appeared to calm down.

113. The officer checked on her at 11.30am when she was still very agitated in her cell. At about 12.00pm, another officer went to her cell to see if she wanted to come out for lunch. She told my investigators that she looked through the observation panel, but she had blocked it with toilet tissue. The officer knocked on the door and called to her but received no response. She then alerted another officer and tried to open the cell door. The door only opened slightly as she had pushed a table behind it, and put a chair on top of the table. As the officer pushed the door, the chair toppled off the table. The woman appeared from behind the privacy screen (a panel that provides some privacy for women whist using the toilet) screaming and shouting, telling her to get out. She picked up the chair and threw it towards the officer who closed the door to avoid it hitting her.

114. The officer went to the office and told the senior officers what had happened. As the woman was on an ACCT, it was important that staff were able to observe her and be able to get access to her quickly in case of emergency. An SO took some lunch to her cell. The barricade was still in place and the observation panel remained blocked. Another SO went outside to check the cell from the window outside but could not see in. The SO tried to open the door. It opened a few inches and the officer managed to get his hand into the cell and push the obstruction back. After several minutes they were able to open the door wide enough to enter the cell. The officer saw her sitting on the toilet holding her knees. She was verbally abusive towards him. He told investigators that he offered her the plate of food in an attempt to diffuse the situation but she would not take it. The officer and the SO then started to remove some of the furniture from her cell to prevent her making further barricades. The woman did not seem to mind that staff were removing the furniture until they tried to remove the locker which housed some of her personal possessions. The woman then started shouting. She attempted to hit the officer but he caught her arm before it made contact.

115. Various staff and prisoners refer to the woman as “losing it”. She was shouting and struggling. An officer entered the cell and took her other arm. All staff involved told investigators that they tried to calm her and de-escalate the situation by talking to her. However, she kept shouting and kicking out at staff and refused to comply. The woman was restrained and cuffs were applied. The SO told investigators that she again tried to ask her what was wrong, but the woman would not acknowledge her and continued to struggle. The SO took the decision that she needed to be moved to the Care Support and Reintegration Unit (CSRU). She told my investigators, “I tried de-escalating, I couldn’t de-escalate the situation. She was under restraint it couldn’t escalate any more. However … I couldn’t leave her in her cell in the manner that she was in.”

116. The CSRU is approximately 50 to 100 yards from Waite wing. The woman was escorted by three officers. She shouted the whole time. She would walk a few steps, then stop and struggle again. She kept kicking out at staff. The orderly officer on duty (a principal officer who takes charge of any incidents) joined the officers en route. He told my investigators that when he arrived she was being very abusive, shouting and kicking. They stopped, and the orderly officer recalled trying to persuade her to stand up without help and walk in a decent fashion. She refused this request by screaming more verbal abuse and continued to kick. The orderly officer reported that they continued using the appropriate control and restraint techniques to move her. The orderly officer told my investigators:

> "I wanted to put her into a normal location; I wanted to put her into a furnished room. So we stopped at the first available cell that they'd prepared for her and to give her the opportunity again to be compliant. She refused this again by kicking out at the staff and being abusive. So therefore, because she was so aggressive and her manner was so difficult to deal with, they only next option was to take her to the special accommodation which we did and again gave her a further opportunity to calm the situation, to de-escalate the situation, again she continued to be quite aggressive and quite violent with staff and therefore we continued with the relocation in the special accommodation. At some point somebody mentioned to me that she had a bad leg, to what extent they didn't know and neither did I so we asked the medical staff if they could help. On site the medical staff that were there couldn't actually give any specifics and one nurse left to try and make some phone calls to find out which would be a case of checking IMR (medical record), things like that which I knew was going to take some time. She was still being quite difficult with the staff and she was lying face down on the floor. Because I was aware of possible positional asphyxia and also staff getting tired, it could end up that the situation could escalate as opposed to de-escalate so I authorised them to carry out the figure of four (a technique used to hold a person down, imobilising their arms and legs, whilst staff leave the cell) in accordance with approved methods and get the staff out of the cell as soon as possible."

117. In accordance with policy, whilst the woman was in the special cell, she was subject to a constant watch. This was done by an officer who talked with her for some time but she was being verbally abusive, angry and pacing up and down the cell. The officer recalled that she was also trying to hurt her head at some point. At the time, the officer was bringing her dog into the CSRU as part of an initiative known as PAT (Pets as Therapy) to help as a calming influence. She asked the woman if she would like to see the dog, and she said she would. The officer called for the dog. She told my investigators that the woman had said, "don't let the dog see me, I don't look right." She seemed very confused. She said she wanted to see her sister but she did not know where she was. The officer told my investigators that the woman kept saying she knew she was coming to the CSRU because they had put her in

the end cell on the wing. The officer described her behaviour as very bizarre. She would be talking and then she would stop and ignore her.

118. The second officer took over the constant watch from the first officer at approximately 1.00pm. He told my investigators: "She was bizarre in some of the things she was saying. She told me that she saw things, she said I see things and I said what do you mean and she said I see things before they happen and I said do you mean a bit like a medium and she said yes … Her eyes seemed to divert away from her as if she was looking at something … she seemed preoccupied with something else that was in the room at times and then she'd focus back on me as I was talking to her … She said to me, I knew I was coming here today … that's why I brought my cardigan."

119. The officer said that the woman went silent at times. She then started talking positively about her daughter. She also spoke about a drawing she had done of a child handing her mother daffodils. The officer said: "She was very preoccupied … and she talked about 'them' and looked up 'at them' … I said, who do you mean by them? And again she just averted her eyes up. She was very chatty but sometimes utterly bizarre in what she was coming out with. She said to me an Asian family would die that day in a fire and I said how did you know that? And she said because I can see it. She actually said that she didn't want to die, she said I don't want to die, they want me to, looking up again, she said but I know I can't and again would start talking about things in the future … she acted as if there was something else there, as if there was maybe – how a person would act if there was a fly in the room."

120. Prisoners should only be held in special accommodation for as short a time as possible, so the second officer and a SO talked to her about moving into a normal cell. She was reluctant, and they tried to persuade her by saying she would be more comfortable, would have a proper bed, wash basin and toilet. They would also be able to get her something to eat and drink and something to read. The SO recalled that the woman said that she did not "trust the room".

121. Other women on the wing were also encouraging her to go into a normal cell. It took about half an hour to persuade her, but she eventually agreed to move into cell 1, which was the end cell on the unit. The woman walked unaided to the cell just before 2.00pm.

122. Once she had moved to cell 1, the observations were reduced to four an hour. The second officer told my investigators that she checked the woman more frequently because of her "strange" behaviour. She hoped that the woman might open up to her, but was not concerned then that she would self harm.

123. In the main, the checks were conducted by the first and second officers, although two SO's also made checks. The second officer arranged some food and together with the first officer took it into her. She said that the woman was sitting on the bed and nodded, but did not say anything. The second officer said that, once the woman had gone into cell 1, she did not engage with staff at all. The woman rolled up her bedding and sat on it behind the door. The

CCTV footage shows staff crouching at the door in an attempt to talk to her. The officer said that once someone has come out of the special cell and calmed down, staff normally try to go into their cell and sit down and talk to them. As she was either distant or aggressive, and was sitting behind the door, they could not do this.

124. The second officer gave her a plastic knife to butter her bread, and remembers that she started waving it around. She said that the woman paced around the cell and would not talk to her. Then suddenly she would stop and just stare at her. The officer found her to be completely different to how she had presented when she was in the special cell. The woman then began ripping her mattress covers and sheeting. The officer told my investigators that the woman did not appear to be making ligatures, just randomly ripping bedding and throwing it around the room. The first officer and one of the SOs said they saw her holding up a short strip of bedding less than a foot long and made at note in the ACCT at 3.00pm. The next time the second officer checked her she had curled up on the bedding and appeared to be asleep.

125. Just before 3.00pm, a nurse went to see the woman. The nurse said she could see her but she would not communicate with her. The nurse went to the office and phoned the MHIT. It was her opinion that the woman needed urgently to be assessed by the psychiatrist. She was told that the woman was down to see the psychiatrist on their next visit (this would have been the following day).

126. At 3.45pm, the first officer noted in the woman's ACCT that she was sitting behind the door and had responded by making a moaning noise. At 4.05pm, the officer noted in the ACCT that the woman was standing and had threatened both her and the SO with the plastic knife.

127. The nurse had left the wing to collect the medical records and medication for several women on the CSRU, including hers. It took longer to locate all the files than she had expected. She returned to the CSRU at about 4.00pm. Once she had secured the records and medication, the nurse then went to the woman's cell to check how she was. This was approximately 4.15pm. When she reached the cell, the observation panel was blocked with toilet roll. As cell 1 is the cell closest to the end of the building, the nurse went outside to look in through the cell window and saw her hanging from a ligature at the window. She ran back into the building whilst shouting to the SO that they needed an ambulance and to call hotel four (the healthcare emergency response) on the radio.

128. The SO pressed the general alarm. This is logged at 4.16pm. Two officers entered the cell immediately with the SO. A wing officer supported the woman's body, whilst the first officer cut the ligature. They then laid the woman on the floor where the nurse commenced cardio pulmonary resuscitation (CPR). The ambulance was called at 4.16pm. Other staff arrived quickly. Two further nurses arrived to assist with CPR. They were further assisted by one of the SO's and by the first officer. The ambulance did not arrive quickly and was called for again at 4.25pm, 4.30pm and 4.40pm by

the SO. The duty governor also followed this up. Nurses continued CPR all this time. In total there were seven members of healthcare staff, including the head of healthcare, but no one called for a defibrillator.

129. The ambulance arrived at Styal at 4.47pm and paramedics were with the woman by 4.50pm. The ambulance left the prison at 5.36pm and took her to Wythenshawe Hospital where she was pronounced dead at 5.54pm.

## ACTION FOLLOWING THE WOMAN'S DEATH

### Contacting the woman's family

130. When the woman had arrived at Styal, she had not provided contact details of her next of kin. This caused some delays in contacting her sister. Staff looked through the woman's visit records and found details of a Reverend who had visited her and knew her well. The Reverend joined the Governor and the appointed family liaison officer to break the news to the woman's sister at her home.

131. The woman's sister was offered the opportunity to visit Styal which she took up. She also attended a memorial service at the prison. The woman's sister has spoken highly of the care and information she received from Styal, in particular the on going support from the family liaison officer.

### Contingency plans

132. Styal's death in custody contingency plans were implemented fully, and all actions were well recorded. There was a staff debrief. Staff felt supported and the care team made themselves known to those staff involved.

133. The Samaritans attended and were present whilst staff informed prisoners at their individual cells on Waite wing and the CSRU. One of The woman's friends, who was particularly upset, was moved to the first night centre to allow closer attention. All women subject to ACCT procedures were reviewed that evening.

134. Subsequently, a memorial service was held which was well attended, and a collection made. Her sister asked this to be spent on art facilities and supplies as a fitting tribute to the woman.

## ISSUES

135. As I made clear at the beginning of this report, the majority of women at Styal are vulnerable with complex backgrounds and multiple problems. Many have experienced drug misuse, mental health difficulties, and have histories of physical and sexual abuse. Consequently my findings, conclusions and recommendations must be seen in that context.

### *Levels of self harm and suicide prevention*

136. In March 2006, there were 136 recorded incidents of self harm at Styal. Of these, 45 were by women housed on Waite wing, and 77 by women on the CSRU. In April, there were 117 recorded incidents of self harm, 34 on Waite wing and 77 in the CSRU. (Many of these incidents involve the same women who are frequent self harmers.) In every case, staff must attend and deal with the situation. Of the 117 recorded incidents in April 2006, six women were found hanging, 37 attempted to self strangulate, 59 were incidents of cutting, 11 of noose making, there were two suffocation attempts, one of punching self, and one of swallowing something dangerous.

137. From January to the end of April, staff opened 267 ACCT forms. At the time the woman died, there were 27 open ACCTs across the prison. There were 18 open on Waite wing, three on the CSRU and six across the houses.

138. From analysing the orderly officer reports, my investigators found that, in the week before the woman's death (2 to 9 May), the orderly officer responded to 27 incidents of self harm. In 11 of these, the woman was aggressive or violent towards staff. There were also two occasions when a woman was violent to others in incidents that did not involve self harm.

139. My investigators found that suicide and self harm prevention work is given a high profile in Styal, clearly supported from the top down. The policies were of a good standard and recording practices were improving.

140. My investigators examined the three ACCT forms opened on her and found them to be of a reasonable standard. The second ACCT was opened on 25 April due to her low mood. It was closed the following day. The reasons given for its closure were valid. However, the woman was unpredictable and prone to mood swings. Given the dramatic change in presentation, I believe the document could and probably should have remained open longer. With the benefit of hindsight, her mood was low the following day and she self harmed. There was one delay on the ACCT that was opened on 27 April, as the care map was not completed until 4 May.

141. My investigators examined a number of other ACCT forms and found them to be of a generally good standard, providing clear evidence of interaction with women. However, there were too many cases, as with the woman, where reviews and closures of ACCTs took place with only an SO and officer present. A SO said that it was often difficult to gather a multi-agency panel for reviews, particularly given the number of women. I appreciate the difficulties

and the importance of drawing upon the SO's knowledge. Nevertheless, the quality of interaction and decision making is certain to be enhanced when a multidisciplinary approach is taken. This is particularly the case for women who are detoxing, when having either their CARATs worker or someone from the substance misuse team present could prove useful. (My investigators discussed these matters with the governor and the head of safer custody, at the time of the investigation.)

142. The woman's sister also felt particularly strongly that representatives of the mental health in-reach team should be invited to attend. I understand the concern. However, whilst it is important to have a multi disciplinary approach, with, whenever possible, healthcare input, arguably the care is enhanced when staff that know the woman and have continuing involvement are involved. Certainly, it would be helpful to obtain the view of key personnel that may not always be able to attend in person.

143. There were several entries in the woman's ACCT forms where an officer noted that she was with other staff, i.e. nurse, CARATs, chaplaincy. However, non discipline staff rarely made an entry. Some said they would not necessarily know who was on an ACCT. Most said that, if they were aware and anything had concerned them, they would make an entry. However, all contact can build up a picture. Indeed, given the woman's unpredictability, it would have been useful for discipline staff to be aware of other interactions. I understand that Waite wing is a busy environment, and if staff are just passing it would not be reasonable for every contact with a woman on an ACCT to be noted. However, few discipline staff are trained in drug or mental health issues and multidisciplinary observations provide a more holistic approach.

**Non discipline staff, including members of the chaplaincy, should be reminded that it is their personal responsibility to identify those women subject to enhanced support by way of the ACCT, and should also be reminded of the importance of making meaningful entries in the on going record.**

144. Staff at the MHRC said that the ACCT forms did not always travel with the women.

**Staff involved in organising the movement of women around the prison should be reminded of the importance of the ACCT documentation accompanying the women at all times to ensure continuity of care.**

***Family involvement in suicide prevention***

145. The woman's sister was justifiably concerned that she was not aware the woman had harmed herself so seriously on 7 May. Prison Service Order (PSO) 2700, Suicide and self harm, states:

*3.4 Follow-up actions, and care for prisoners who have self-harmed*

*3.4.3 After consultation with the prisoner, the nominated next of kin must be notified, unless:*

*There is a clinical reason not to, or;*

*If aged 18 and over, the prisoner does not consent, or;*

*The prisoner's support plan indicates otherwise* (*e.g. in the case of a prisoner who repetitively self-harms).*

*Where appropriate, after serious incidents of self-harm consideration should be given to allowing the prisoner themselves the opportunity to notify the next of kin by a phone call and/or an extra exceptional visit.*

146. I acknowledge that most of the women are adults and can make a decision whether to contact their family. Some may have unhappy family relationships or no family to support them, or may not wish to upset them. However, the woman was clear that she had family support. The Prison Service, as a whole, seems not to involve families in suicide prevention and support as much as it could. In some cases, like this one, family support could complement the locally available support. Indeed, there have been other situations at Styal, where the staff have been able to involve families, however this was not routine at the time of the investigation.

**The governor should remind staff that consideration should be given to contacting families in line with PSO 2700 when a prisoner commits serious self harm. Staff should also encourage women on ACCTs to speak with their supportive family members where appropriate. This should be included in the local suicide prevention policy.**

147. Once the news had been broken to the woman's sister, she was offered assistance with the funeral, and given the chance to visit Styal where a memorial service was organised.

**The prison family liaison officer made herself available to the woman's sister and has provided on-going assistance that has been greatly appreciated. This is an example of good practice and the liaison officer should be commended for her actions.**

### *Waite wing*

148. Waite wing can house up to 174 women over the two sides (X and Y), and is usually full. Most cells are double cells. As described earlier, the women housed on Waite wing are generally in need of much more support, supervision and care than those located on the individual houses. Women who are detoxing from drugs are housed on Waite wing, along with many women who self harm or who have mental health problems.

149. The wing is set apart from the rest of the prison by a fence. The woman's sister was particularly concerned about the message this sends and how the women in the houses may view Waite wing and vice versa. (In my own report on Styal following the deaths in 2002-03, I took a similar view myself.) My investigators found Waite wing clean, but were struck by the level of noise due to the wing's construction. Efforts had been made to lessen the harshness of

the wing using bright paint, laying carpet and providing plants. (These are welcome improvements made since my earlier report.) However, the sheer number of women on the wing with different needs made it a difficult environment to manage.

150. Waite wing is of a standard design that can be seen in many male prisons that have expanded in recent years. It provides relatively cheap and speedily installed accommodation. But while I know it serves little practical purpose in the short term for me to say so, I do not believe that the design of Waite wing is appropriate for the very vulnerable women who are held there. No wing like Waite wing should ever again be erected in a woman's prison.

151. The staff profile for the wing was 12 staff in the morning, 12 in the afternoon and ten each evening. However, staff told my investigators that in reality there are often ten all day and eight in the evening. On the face of it, this staffing profile seems reasonable. However, several hours of the day are taken up by staff supervising the issuing of medication. The head of healthcare told my investigators that out of the 450 women at Styal, approximately 150 to 170 are on methadone which is administered in the morning. The vast majority of the 450 women are on other medication, many of them multiple medications.

152. Self harm and cell barricades are also an almost daily occurrence on Waite wing as are hospital appointments, either planned or in emergencies. All such occurrences involve intensive use of staff resources.

153. It was clear to my investigators that staff were struggling to provide a full or purposeful regime consistently on Waite wing, and the issuing of detoxification medication dominated the day. My investigators found that there were occasions when women did not always attend the MHRC because there had been problems arranging the movement from the wing.

154. However, my investigators found staff to be committed and compassionate. They were impressed by the interactions between staff and prisoners that they observed. During interviews, staff displayed great knowledge of the women for whom they were caring. However, many found the task almost overwhelming, and said it was difficult to know the right thing to say to the women who were self harming. Staff saw the prevention of suicide as a very real part of their job. One officer told my investigators that, on some days, if they got to the end of the day without a woman dying or going to hospital, they felt they had done their job. Many staff were distressed during interview, some because they had worked with the woman, others because they were clearly stressed.

155. Nevertheless, my investigators were left in no doubt that wing staff felt well supported by management. The governor and senior management team were committed to doing their best for the women in their charge. Styal had a clear direction, and expectations of the standards of care and decency came from the top down. When I conducted my inquiry into the six deaths in 2002-03, I compared the level of resources available to Holloway with the lower level available to Styal. I repeat that comparison here. While I make no formal

recommendation on this occasion, the Director General and Area Manager will wish to consider how best to support the undoubted improvements that have been made at Styal in light of the demands made upon the prison's management and staff. (Commenting on my draft of this report, the solicitors representing the woman's sister asked that I include specific details of the comparative resources available to Styal and Holloway. I regret that I am unable to do so, having neither the expertise nor the authority to conduct a proper review of this matter.)

***Clinical issues***

156. The role of healthcare at Styal is crucial and complex. The head of healthcare explained to my investigators that, on arrival, many women need observation and treatment for drug or alcohol withdrawal. Some women become depressed and exhibit mental health problems. Many will also have physical problems and have not engaged with clinical services outside of prison. Some will have sexual health problems. He said that the key challenge is to identify the problems, and put plans in place quickly, as the average stay for women at Styal is about six weeks.

157. Some clinicians spent a great deal of time with the woman and displayed a high level of compassion.

***Mental health in-reach referrals***

158. There is a permanent mental health nurse based on the CSRU, and a mixture of mental health nurses, general nurses and healthcare assistants based in Waite wing and the healthcare centre.

159. Predominately, the role of nurses on Waite wing is to issue medication and deal with a multitude of primary care issues. If nurses on Waite wing are concerned about the mental health of an individual, they must refer them to the MHIT. Staff in the MHIT are more qualified, can undertake full assessments, and if necessary take women onto their caseload, in much the same way a CPN would in the community. The MHIT has links with the community, and can refer women to the psychiatrist if required.

160. On 3 April 2006, the woman was seen by a nurse from the MHIT. The woman spoke of her admissions to psychiatric hospitals and her on-going treatment in the community by a psychiatrist and CPN. She described her disorders and treatment, including the medications she had been receiving. As a result, the nurse planned to contact Psychiatric hospital for more information regarding her medication, and to refer her to the MHRC for support.

161. The woman was assessed by the MHRC, and attended on a regular basis. My investigators also found evidence that several referrals were made to the MHIT. A nurse from the substance misuse team spoke with the MHIT about The woman's wish to detox and her non-compliance with the detoxification regime. On 25 April, a referral was made after staff opened an ACCT following her low mood. The woman said she knew she had been referred to

the MHIT, but no one had visited her. A SO said an urgent referral was made following the woman's self harm on 27 April. The wing mental health nurse said that, as the woman started to deteriorate towards the end of April and beginning of May, she made two paper referrals and several telephone calls to the MHIT. Several officers said they knew that officers and nurses had made referrals. It is of concern that officers also told my investigators that referrals to the MHIT were not treated as urgent and they always needed chasing up.

162. It was not until the woman endangered her life by cutting her leg on 7 May that an SO went to the senior management meeting to express her concerns. The head of healthcare asked the MHIT see the woman the same day. However, it appears there could have been confusion in that some officers said the woman was seeing the in-reach team when she was actually at the MHRC. The woman's behaviour in the MHRC was much calmer than on the wing and the well trained staff there did not have the same cause for concern. Consequently, they did not have reason to refer her to the MHIT. However, nurses on the wing noticed her deteriorating behaviour, and were arguably best placed to raise concerns as they say they did.

163. When the woman arrived at Styal, she had self harmed by cutting her wrist and neck with a razor in the police station the previous day. She had a psychiatric history, and had been under the care of a psychiatrist and CPN in the community. In my view, these circumstances should have triggered an immediate referral to the psychiatrist.

164. Once the woman had been seen on 8 May, a referral was made to the visiting psychiatrist and an appointment made for 11 May. I am impressed that, where there are pressing concerns, an appointment can be facilitated so quickly. However, there were clearly a number of missed opportunities for this referral and assessment to have been made sooner.

165. The MHIT had no record of any paper or telephone referrals for the woman from her arrival to the time of her death. The system has since been changed and my investigators were told that all referrals are now logged in a register.

166. I understand there have been considerable difficulties in managing the MHIT within the rest of the healthcare system at Styal, given the different providers, sources of funding and employment terms. This matter needs to be addressed urgently to ensure the needs of the women at risk are met as appropriately as possible.

**All staff in the MHIT should be reminded that a referral to see the psychiatrist should always be made when a woman has a significant psychiatric history and/or recent care in the community from a psychiatrist and CPN.**

**The system for referral to the MHIT, and the response to referrals that are urgent and those that are normal, should be audited by the head of healthcare. The referrals and response should be subject to time**

**targets. A system should be put in place to evaluate the procedure and its effectiveness regularly.**

167. Cheshire & Wirral Partnership NHS Trust responded to these comments during the drafting stage. They said:

> "The Ombudsman refers to different sources making referrals to the Mental Health In-Reach team. The report did not test out whether those referrals had in fact been received by the Team. The assumption made that they were, however, it is not clear to the Trust that they were in fact received. This may relate to other comments about confusion of staff between the Mental Health Resource Centre & the Mental Health In-Reach team, and to our acceptance that the system for referrals needs to be improved. We have no evidence that the Mental Health In-Reach Team where made aware of issues pertaining to this woman after the initial contact on 03.04.06 up to 08.05.06 when issues were raised via the Prison Brief.
>
> Therefore, as far was we are aware the team response was immediate upon being requested to become involved & therefore criticism re a lack of response would be unfair if they were in fact not made fully aware of the mental health issues. The Report appears to show that three ACCT reviews were opened, at which time no invitations were made to members of the Mental Health In-Reach team to attend.
>
> With regard to referrals, these are being monitored by the Mental Health In-Reach team as part of Performance Indicators & will be reported to the Prison, PCT Head of Healthcare & PCT Commissioners. There are standards for referrals which are 2 days for urgent & 7 days for non-urgent which are reflected in the draft service specification."

168. I agree there was some confusion in terminology between the mental health rescource centre and the mental health in-reach team. However, a number of referrals were made by nurses, and I would expect them to understand the different roles. The investigators asked the mental health in reach team whether they had received any referrals at the time of the investigation. They said they had no record of any referrals. However, they also said they were not formally recording all referrals in a book in the way they are now.

169. I also agree that where there are mental health concerns, it could be advantageous to invite relevant mental health staff. In reality, it may be sensible to ask for input from those who are active in the care given to an individual prisoner.

***Medication issues***

170. As part of her detoxification programme when she arrived at Styal, The woman was prescribed methadone and diazepam. She was later prescribed quinnine sulphate to help with the stomach cramps.

171. Following her consultation with the MHIT on 3 April, the plan included contacting the psychiatric hospital that the woman attended for information regarding her medication. My investigators found no evidence or note of that information being sought until it arrived via fax on 13 April.

172. This is an area of deep concern to the woman's sister. She felt that the woman relied on these drugs for their mood stablizer benefits. Even when she did start taking her medication again, it would have taken time to be in her system and build up to the strength and effectiveness she required.

173. It is of concern that the fax was not acted upon. It is possible that the fax was not placed in the clinical records as neither the RMN nor the senior mental health nurse were aware of it and both made follow up calls to the woman's GP on 27 April. My investigators found no evidence that the medical team considered whether zopiclone should be restarted to provide continuity of care for the woman and she was not prescribed carbamazepine until 3 May. I find such a delay to have been unacceptable.

**Information regarding existing prescribed medication should be requested within 24 hours of a prisoner's reception. Follow–up action should be taken if information is not received promptly. When information is received appropriate action should be taken without delay.**

***Substance misuse management and detoxification***

174. The head of the substance misuse team told my investigators that quick withdrawal can alter the tolerance in the body and consequently, the substance misuse team hoped that the woman would agree to go on the methadone maintenance programme. However, the woman was adamant that she wanted to detox from methadone and the team could not force her to take medication.

175. The woman detoxed quicker than national guidance recommends. The substance misuse team discussed this with her on a number of occasions and expressed their concerns. The nurses on Waite wing were pretty diligent in noting when she did not take all her methadone and in informing the substance misuse team so it was followed up. However, there are no formal processes for this information sharing, and the head of the substance misuse team was concerned that the informal links might not always be effective.

176. The head of the substance misuse team told my investigators of the effects that withdrawal may have on a person's emotional wellbeing. She said that one effect of drugs is to block out painful emotions. Without the drugs, those emotions are re-experienced and can be difficult to deal with. Any underlying mental illness may be exacerbated.

177. The woman's last dose of methadone was 8mls. The head of the substance misuse team said that clinically this is not a large amount but it could have a psychological impact. Others have reported experiencing more side effects

the lower the dosage becomes. Side effects of withdrawing from drugs can continue for some time after the detoxification programme is complete. It is possible that some effects are prevalent well after detoxification is completed, including mood swings and loss of temper.

178. The woman's behaviour deteriorated more rapidly once she had stopped taking methadone. She displayed dramatic mood swings. Staff and prisoners commented how she would be laughing and joking, and within the hour could be crying or aggressive. It is possible that she was experiencing the effects of detoxification which could have exacerbated her existing mental health problems.

179. The woman was assessed by the CARATs team promptly following her arrival at Styal. The CARAT's worker was allocated as her case worker and he attempted to engage with her on several occasions with varying success. My investigation found that his input was appropriate, and demonstrated a good level of care. However, for information to be assimilated and shared, it is important that staff from the substance misuse team and CARATs team work alongside other departments in the prison. It would be beneficial for these professionals to attend as many ACCT reviews of their clients as possible.

**Where a prisoner is subject to an ACCT and is undergoing drug treatment, all key personnel involved in their drug therapy should attend ACCT reviews wherever possible.**

**Crisis management**

180. Once the woman was found, and there were no signs of life, staff were prompt in commencing CPR. Other nurses arrived and between them they continued CPR for approximately 35 minutes whilst they waited for an ambulance to arrive.

**Staff involved in attempts to resuscitate the woman should be commended.**

181. The defibrillator machine has been described as the single most important development in the treatment of cardiac arrest. Defibrillators are used in a variety of public settings, including railway stations, airports and prisons. Given the level of self harm that Styal deals with on a daily basis, the use of automatic external defibrillator machines could save lives.

182. However, despite the availability of defibrillators at Styal and the presence of a number of healthcare staff, no-one asked for a defibrillator. During interviews, it became clear to my investigators that a number of staff did not feel confident in using these machines.

183. At the time of the woman's death, there were two defibrillator machines at Styal. One was based on Waite wing and the other was kept in the healthcare centre. Since the woman has died another defibrillator has been ordered to be kept on the CSRU.

**All healthcare staff should be aware of the location of defibrillator machines, and trained in their use.**

### *Delay in ambulance arriving*

184. An ambulance was called at 4.16pm. The ambulance had not arrived by 4:25pm and was called again at 4.25pm, 4.30pm and 4.40pm by an SO and a governor also followed this up. Nurses continued CPR all this time. In total there were seven members of healthcare staff present, including the head of healthcare.

185. An ambulance arrived at Styal at 4.47pm and paramedics were with the woman by 4.50pm. The ambulance left the prison at 5.36pm.

186. The head of healthcare told my investigators that the relationship with the ambulance service was good and they had not had problems with delays before. The delay was examined by the clinical reviewer from the East Cheshire PCT. She concluded that in future it would be helpful to enable a clinician to speak direct with the ambulance service. This would allow the clinician to outline the seriousness of the condition where there was a delay. It is also important to log when delays occur so that this can be followed up by the PCT.

**The prison health partnership board should consider the learning identified in the clinical review and develop an action plan to address the recommendations.**

### *Record keeping*

187. Throughout the investigation, there were several instances when my investigators could find no notes or recordings of interactions that staff told them about. Additionally, when there were entries on record, some were not clear and signatures were illegible. It is crucial for staff to make a clear note on record when they refer prisoners for assessment or treatment and for clinical staff to note interactions with patients.

**All clinical staff should be reminded of their obligations in record keeping as set out in the relevant Nursing and Midwifery Council Guidelines.**

### *Use of force*

188. When the woman attempted to attack a prison officer on 10 May, staff restrained her. The woman's friends said they could hear her, and some who saw her reported that they had not seen her "lose it" in that way before. All staff told my investigators of the attempts to try to calm her, but she continued to act aggressively and kicked out at staff.

189. A SO applied ratchet handcuffs. The orderly officer explained that cuffs prevent prisoners from lashing out with their hands. When prisoners realise this, situations tend to de-escalate and staff are encouraged to use ratchet cuffs at the earliest opportunity for the safety of both prisoners and staff.

190. From the time the woman entered the CSRU, there was CCTV recording that my investigators have subsequently viewed. This shows the officers involved in the control and restraint, with the orderly officer following and a wing officer standing behind the woman. Staff told my investigators they tried to calm her to see if she could go into a normal cell. However, she is seen struggling and kicking out. At one point, the orderly officer can be seen putting his foot near the woman twice. In interview, the orderly officer said:

> *"That was the point where we'd come to a stop to give her the opportunity to calm down and her response as I've said was to kick out… forwards and backwards. What I was doing there was putting my leg across to prevent her from kicking the officer that was stood next to me, it was just pure reaction to prevent her from hurting the officers."*

191. I am satisfied that it was necessary to restrain the woman for her own safety and that of others. I am also satisfied that the orderly officer's actions were warranted and not aggressive, unnecessary or improper.

***Care Support and Reintegration Unit (CSRU)***

210. The CSRU is a specialist unit which has space for 10 women who commit disciplinary offences, are violent, are high risk repetitive self harmers, or a mixture of any of the above. Such women present the most challenging of behaviours and require intensive supervision.

211. My investigators found the CSRU to be clean and bright. The aim is that women will spend as short a time as possible on the unit and will receive more intensive support to enable them to return to Waite wing. One of the 10 cells is a 'safer cell' which has fewer ligature points than a normal cell and which was occupied at the time the woman was in the CSRU. There is one special cell which has no furniture. There is also a 'calm down room' with special lighting and comfortable furniture to help women relax when upset.

212. The staff are specifically selected and trained to work on the CSRU. There is a nurse based there and a high staff to prisoner ratio compared to other parts of the prison. At the time of the investigation, Styal was experimenting with the use of a PAT (pets as therapy) dog.

213. The women were encouraged to maintain as full a regime as possible. This included attending MHRC or the CALM centre as well as education or work where possible. My investigators spent time on the CSRU. The women were often out of their cells and talking to staff. Staff were seen chatting to the women on the unit or in their cells. In some respects, it was a more relaxed, albeit far more controlled, environment than other parts of the prison.

However, this is not to underestimnate the stress levels of both staff and prisoners on the CSRU.

***Use of special cell***

214. Staff gave the woman the opportunity on several occasions to calm down so that she could be placed in a normal cell. However, she remained volatile and difficult to handle. The orderly officer took the decision to place her in special accommodation to calm down.

215. Prison Service Order (PSO) 2700, Suicide and self harm, states:

> "Special accommodation"
>
> *"Prisoners identified as being at risk of suicide or self-harm must not be placed in an unfurnished cell. Precise definitions of the terms unfurnished rooms, strip cells or strip conditions are now blurred across the estate. In the context of caring for prisoners identified as being at risk of suicide/self-injury, strip cell and strip conditions refer to bare unfurnished cells which do not contain furniture, fittings, bedding and clothing."*
>
> *"In exceptional circumstances, such prisoners who are additionally identified as violent or refractory may be held in special accommodation (as defined in PSO 1600, Use of Force), for the shortest possible time. Once the violent or refractory behaviour has ceased, such prisoners must be removed from special accommodation. Appropriate supervision measures must be in place to ensure the safety of the prisoner during the period they remain in special accommodation. During this period, staff must continue to document all observations and changes in circumstances in the daily supervision and support record in the F2052SH."*

216. The woman was constantly observed in the special cell, first by the first officer and then by the second officer. They spent time talking with her, and this was recorded in a special log. Once the woman had calmed down, it took some time to persuade her to move to a normal cell. The woman remained in the special cell for about an hour and a half.

217. There is one safer cell on the CSRU. At the time the woman was on the CSRU it was occupied by another woman who was deemed to be at particularly high risk of made ligatures.

218. During her time in the CSRU, the woman was exhibiting bizarre behaviour. In the special cell she talked about knowing that she was going there that day. Staff described her looking around the room as if there was a fly there. She was unpredictable and volatile

***Safety algorithm and segregation paperwork***

219. One of the safeguards in place to protect those placed in the CSRU (or in any segregation unit) is a segregation safety algorithm. This is completed by a

nurse to help the authorising governor decide if the unit is the appropriate place for the prisoner concerned. The guidance states that the algorithm should be completed within two hours of segregation. It also says that the nurse is required to see the individual before completing the algorithm.

220. The CSRU nurse told my investigators that she went to see the woman, but at the time the woman did not want to communicate with her. She also said that, when she signed the safety algorithm, she felt the woman's mental state would not deteriorate further by being in the CSRU. She had not examined the woman's medical records as they were not on the unit. She then went to locate them.

221. The nurse acknowledged that being on the CSRU can affect a woman's mental health as it can be a stressful environment, although the staff ratio of specifically selected and trained staff afforded a higher level of one to one attention than possible on the wings. She was confident that she could communicate to staff any concerns she might have.

222. The CSRU nurse was not present when the woman was in the special cell and exhibiting bizarre behaviour, and she did not complete the safety algorithm as comprehensively as she could have done. To the question, "has the person self harmed in this period of custody/are they on an open F2052SH (the former document that has been updated to ACCT) or is the person currently taking anti-psychotic medication?" the reply was yes. This led onto the question, "do you think the prisoner's health will deteriorate significantly if segregated?" the answer was no. To the question, "does the prisoner show signs of being acutely unwell (eg. Psychotic) at the present time?" She replied no. To the question, "do you think that the prisoner will be unable to cope with a period of segregation at this time?" the nurse replied no. She did not circle what action was needed, and did not specify whether there were healthcare reasons to advise against segregation.

**The governor should remind clinical staff who complete safety algorithms of the importance of making themselves aware of recent events, behaviour and clinical conditions, and to fully and accurately complete the algorithm.**

223. When a prisoner is held in the segregation unit, it must be authorised by a governor grade. The orderly officer briefed the duty governor of the situation. The duty governor had been to the CSRU at about 11.30am and seen the prisoners held there. He agreed that the woman should be located in the special cell whilst she calmed down and should be moved at the earliest opportunity. The duty governor signed the necessary form to authorise the initial segregation. Part C of the form required the duty governor to decide whether the CSRU, the wing, or healthcare, would be the most appropriate location. There is no inpatient facility at Styal so the only options for the woman were the wing or CSRU. This part of the form was not completed. The governor explained that he planned to check the woman late that afternoon and make a decision once she had settled down.

224. It was of particular concern to the woman's sister, that the duty governor authorised the initial segregation without seeing the woman. During interview with the duty governor he said;

> "it was just very initial stage to give the authority to hold her in the CSRU conditions in which case going down I would speak to her, speak to everybody that was available at the time and then make a decision as to whether it would continue or I would put her back onto the wing or whatever was suitable depending on the position. There's a sense of that because somebody coming out of the special accommodation into a CSRU cell can change dramatically so you need to see how that person is going to respond firstly before you dive in there … so this is the kind of basis that I was working on for let's see how she's responding, go down, have a word, have a chat and then say well okay yeah, you're able and you're able to go back to the wing or no we need to keep you here and make a more formal decision on that."

225. Following the concerns raised by the woman's sister, my investigators asked the duty governor if he had anything further to add. He said;

> "I was briefed by the people who knew the woman and were in a position to give an informed account of the situation. It is not a requirement for me to see her physically in order to sign the algorithm, it is the authorising signature only. I was satisfied with the brief that the orderly officer gave me and the subsequent briefs thereafter. As I have said I was going back to the CSRU when I was informed she had moved out of the special cell, so I planned to see her between four and five o'clock and review the position with staff at that point. I deeply regret the loss of the woman, but having reviewed the situation and with hindsight the actions taken were appropriate under the circumstances."

226. Certainly, the duty governor was not specifically required to see the woman in person before authorising her initial segregation and did not act inappropriately. However, I have great sympathy with the idea that the signature by a governor to authorise the segration could become a rubber stamping exercise. In this case, the decision was taken by a principal officer, in the prescence of two senior officers. In this woman's situation, it is difficult to see that a governor would have come to a different decision. However, I do agree that, wherever possible, a governor should see the person being segregated in person. The Prison Service may wish to give future consideration to this general issue.

***Time in cell 1***

227. Staff noted that the woman did not engage with staff once she had moved to the normal cell. They took her some lunch and a coffee and she did not acknowledge them. The CCTV footage clearly shows staff attending her cell frequently and spending time there trying to talk with her.

228. The second officer told my investigators that she saw the woman tearing up her bedding. She said that she had seen other prisoners do this, normally for ligatures. The woman did not appear to be making ligatures, but randomly tearing the bedding. My investigator asked her whether, in such instances, an officer should go in to a cell to remove the bedding. She replied:

> "Experience tells you that when someone is being aggressive and things like that, you'd wait until they're calm before you try and engage, you try and de-escalate them by talking to them but sometimes some women are best left to calm down on their own, some women are best being spoken to but at that point, because we were checking her frequently … she wasn't engaging."

229. The second officer also explained that at times the woman was sitting behind the door. Entering the cell would have meant restraining her with the risk of inflaming the situation. I accept this was so. The woman's behaviour had appeared violent to others rather than to herself and tearing the bedding appeared to be a reaction to her frustration and anger. I understand how the officers reached their decision. However, further to my investigations of other deaths in prison custody, I am all too aware that small lengths of material can be used as ligatures and I would wish staff should be alert to the dangers.

230. Clearly there is always a judement call to be made when decided how to deal with a woman who is not responding to any verbal efforts. However, this is an area which is of particular concern to the woman's sister.

## RECOMMENDATIONS

1. Non discipline staff, including members of the chaplaincy, should be reminded that it is their personal responsibility to identify those women subject to enhanced support by way of the ACCT, and should also be reminded of the importance of making meaningful entries in the on going record.

   *The Prison Service accepted this recommendation and responded:*

   *"This need has been identified via the Safe Guarding meeting. This is a multi disciplinary team meeting. All staff are made aware of the meeting and required attendance via morning briefings, the weekly bulletin and the minutes are published and sent to all staff via global email. . Plans are in place that the Safer Custody Principal Officer and the Psychology department will produce a training package which will include individual's responsibilities when ACCT documents are open.*

   *All non discipline staff who offer a service to prisoners have a duty to identify those women who are on ACCT documents and make entries accordingly. This should be monitored through the quality checks of ACCT carried out by Safer Custody Princiapl Officer and Governors.*

   *The local Safer Custody group will identify a person to be responsible for checking those prisoners who are on ACCT documents and what interventions they are undertaking and thus check ACCT documents accordingly. When entries do not exist this will be directed to the Head of Safer Custody who will then liaise with that individual's line manager.*

   *This training and the role of the local Safer Custody group will be advertised through Notice to Staff and Prisoners, delivery of a full staff meeting and via the intranet. A process is being considered to incorporate a form of Continuing Professional Development for all staff involved in the ACCT process. A training database will be maintained and this will be audited against it.*

   *Nationally the revised PSO 2700, due for publication Spring 2007, has increased mention of the role of the multi faith chaplaincy team in the care of at-risk prisoners.This need has been identified via the Safe Guarding meeting. This is a multi disciplinary team meeting. All staff are made aware of the meeting and required attendance via morning briefings, the weekly bulletin and the minutes are published and sent to all staff via global email.*"

2. Staff involved in organising the movement of women around the prison should be reminded of the importance of the ACCT documentation accompanying the women at all times to ensure continuity of care.

*The Prison Service accepted this recommendation and responded:*

*"As part of the training to be delivered to staff by the local safer custody team, they will be advised that this is the process to be adhered to. All staff receiving prisoners throughout the day have a duty to familiarise themselves with people on open ACCT forms and ensure they receive the ACCT document and make appropriate entries. This will be monitored through quality checks as noted in the previous point.*

*This training and the role of the local safer custody group will be advertised through Notice to Staff and Prisoners, delivery of a full staff meeting and via the intranet.*

*PSO 2700 states that all establishments must have a local suicide and self-harm prevention strategy that either ensures the movement of the F2052SH with the prisoner when he/she participates in activities (in which case, to preserve discretion, local arrangements must ensure the F2052SH is conveyed as discreetly as possible), or informs the receiving member of staff (e.g. in the prisoners' workplace) of the prisoner's status, and allows them to input to the F2052SH daily record."*

3. The governor should remind staff that consideration should be given to contacting families in line with PSO 2700 when a prisoner commits serious self harm. Staff should also encourage women on ACCTs to speak with their supportive family members where appropriate. This should be included in the local suicide prevention policy.

*The Prison Service accepted this recommendation and responded:*

*"This point should be reinforced through offenders Personal Officers and highlighted in the Care Plan during ACCT reviews. In addition a full staff meeting will be held to discuss this further and details will also appear in the Governors Newsletter Straight talking.*

*Nationally contact with family after a self-harm incident is covered in PSO 2700 (Suicide Prevention). However, the revised PSO 2700 (due for publication in spring 2007) will include more to encourage family contact; building on the introduction of ACCT that itself encourages family involvement"*

4. All staff in the MHIT should be reminded that a referral to see the psychiatrist should always be made when a woman has a significant psychiatric history and/or recent care in the community from a psychiatrist and CPN.

*The Prison Service accepted this recommendation and responded:*

> *"This process should become part of the induction process/first night centre interview. It should be completed by the person who initially finds out this information (discipline officer; In reach team member). A note that this has taken place should be made in the appropriate paperwork (e.g. ACCT documents; observation book, wing history file). This point has also been incorporated and formalised through a change in the Service Level Agreement, which is being formalised by the In reach team as a Standard."*

5. The system for referral to the MHIT, and the response to referrals that are urgent and those that are normal, should be audited by the head of healthcare. The referrals and response should be subject to time targets. A system should be put in place to evaluate the procedure and its effectiveness regularly.

*The Prison Service accepted this recommendation and responded:*

> *"The referral process for the Mental Health In reach team should be reviewed and is currently being done so via the Service Level Agreement and also through quarterly checks. All referrals should receive a priority weighting and a database should be formulated which is overseen by the administration workers within healthcare that evidenced this process. Those referrals deemed priority should be passed on to the appropriate member of staff and they should acknowledge receipt of the referral and planned action which can then be recorded on the database accordingly.*

6. Information regarding existing prescribed medication should be requested within 24 hours of a prisoner's reception. Follow–up action should be taken if information is not received promptly. When information is received, appropriate action should be taken without delay.

*The Prison Service accepted this recommendation and responded:*

> *"First Night Centre staff will contact GP or CDT for information the morning after reception to prison. A record of contact will be made in the clinical records and will be followed up to ensure information is received. On receipt this will be presented to the Prison Doctor at the earliest opportunity to prescribe treatment to ensure continuity of care and treatment".*

7. Where a prisoner is subject to an ACCT and is undergoing drug treatment, all key personnel involved in their drug therapy should attend ACCT reviews wherever possible.

*The Prison Service accepted this recommendation and responded:*

> *"Through training provided by the Safer Custody group all personnel should know their attendance at ACCT reviews is required when they are working with individuals. If they are unable to attend a written input should be provided. This should be overseen by the ACCT review chair and if non compliant the head of the safer custody team should be notified who can liaise with line managers. Such tasks should be reflected in individuals SPDR's. Currently the ACCT Prison Service Instruction (18/2005) says the ACCT case review should "identify the most urgent problems and needs of the prisoner/trainee, and the activities and people best able to provide support, and reflect these issues and solutions in the CAREMAP ". The revised PSO 2700 (Suicide Prevention) that is due for publication this spring aims to strengthen the requirements around the involvement of relevant specialists and others, including family, in ACCT case reviews".*

8. All healthcare staff should be aware of the location of defibrillator machines, and trained in their use.

*The Prison Service accepted this recommendation and responded:*

> *"To place a card in emergency bag informing staff of exact whereabouts of defib in healthcare areas. A training programme is now in place."*

9. The prison health partnership board should consider the learning identified in the clinical review and develop an action plan to address the recommendations.

*The Prison Service accepted this recommendation and said it will be actioned by the head of healthcare and reviewed at the Provider Board Meeting.*

10. All clinical staff should be reminded of their obligations in record keeping as set out in the relevant Nursing and Midwifery Council Guidelines.

*The Prison Service accepted this recommendation and responded:*

> *"Clinical staff should receive regular supervision and line management and such basic process should be recorded in their SPDR as part of their generic role. Line managers should regularly undertake quality checks of such processes to ensure this is taking place and if not address through poor performance as this is a basic role that every clinican has a duty of care to complete. Notes should be made in Wing*

*History sheets; ACCT documents (where appropriate); medical records and observation book."*

11. The governor should remind clinical staff who complete safety algorithms of the importance of making themselves aware of recent events, behaviour and clinical conditions, and to fully and accurately complete the algorithm.

*The Prison Service accepted this recommendation and responded:*

*"All staff should familiarise themselves with the morning meeting minutes that are located on the intranet. All staff should read the observation book when they go on specific accommodation. In addition all members of staff should familiarise themselves with the wing history sheet and any other pertinent documents (e.g. TAB/ACCT) prior to seeing individual prisoners. This will be standard duties that are required by all staff and will be monitored through SPDR for staff adherence. This will also be monitored through the bilat process with staff and functional heads. It is important to acknowledge however that for many staff it was recognised that they were well informed and in general entries were of a good standard."*

**GOOD PRACTICE**

1. The family liaison officer made herself available to the woman's sister and has provided on-going assistance that has been greatly appreciated. This is an example of good practice and she should be commended for her actions.

*The Prison Service responded:*

*"The Governor to present the family liaison officer (a governor herself) with a letter of thanks and a small gift of appreciation during one of the morning meetings. A nomination to be made for Performance recognition and comments recorded accordingly in SPDR. Could also be publicised in News Item of the Day which is on the Intranet for all staff to view."*

2. Staff involved in attempts to resuscitate the woman should be commended.

*The Prison Service responded:*

*"This could be done via Performance recognition, noted in SPDRs and on the Intranet and during the morning briefing (notes of which are available on the Intranet)."*