

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a woman at HMP
Peterborough in May 2014**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a woman, from asphyxia at HMP Peterborough, on 16 May 2014. She was 40 years old. I offer my condolences to the woman's family and friends.

One of the ombudsman's investigators carried out the investigation. A reviewer commissioned by the NHS reviewed the woman's clinical care in prison. The prison co-operated with the investigation.

The woman had a long history of mental health problems and had spent time in hospital and in supported housing in the community. During her four days at Peterborough, prison staff initially managed her as an in-patient in the healthcare centre. While there, she self-harmed five times but staff did not review the suicide and self-harm support appropriately. The evening before she died, the woman threw a cup of hot water at a prison officer. The next day, the mental health in-reach team concluded that she was fit to go to the segregation unit to face a charge of assaulting the officer. A manager opened and adjourned the disciplinary hearing at 11.25am, but the woman remained in the segregation unit. At 11.50am, an officer found her unresponsive with a plastic bag over her head. Efforts to resuscitate her were unsuccessful.

I am concerned that there were a number of shortcomings in the management of the woman's risk of suicide and self-harm. I am also not satisfied that it was reasonable to assess the woman as suitable for segregation. The medical assessment before segregating a prisoner specifically aims to exclude people who are waiting for a transfer or referral to a mental health setting and those who are self-harming and potentially suicidal; all of these factors applied to the woman. The woman was a complex and impulsive person, which made her management difficult, but the investigation has identified concerns about the standard of mental healthcare and support the woman received at the prison. These are issues the prison needs to address to help ensure the safety of other women prisoners with mental health problems.

This version of my report, published on my website, has been amended to remove the names of the woman who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

April 2015

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SUMMARY

1. The woman was remanded to HMP Peterborough on 12 May 2014, after her arrest for arson and criminal damage. She was 40 years old and it was her first time in prison. She had a long history of mental health problems and had been an in-patient in hospital. More recently, she had lived in supported housing in the community. The woman was impulsive and unpredictable and had threatened violence towards staff and other patients in mental health settings. She suffered from paranoia and sometimes heard voices. The woman had a diagnosis of emotionally unstable personality disorder. She often self-harmed by tying ligatures around her neck, by cutting herself and taking overdoses of medication. Sometimes she intended to end her life.
2. When the woman arrived at the prison, healthcare staff admitted her to the prison's healthcare centre and began ACCT procedures – the Prison Service care planning system to support prisoners at risk of suicide and self-harm. Mental health staff services had sent a detailed 22-page fax to the prison with important background information about the woman's care, but several staff involved in the woman's care had not seen it.
3. The next day, 13 May, staff reviewed the woman's risk and continued to monitor her twice an hour. She said she felt anxious and had not slept well. A mental health nurse assessed her that afternoon, but did not allocate a caseworker or refer the woman to a psychiatrist urgently. During the night, the woman tied two ligatures around her neck. The next day, 14 May, she cut her wrist and tried to choke herself. At an ACCT case review that day, the case manager assessed her level of risk of suicide and self-harm as high and increased her observations to four an hour.
4. On 15 May, the woman put tissues down her throat and told a nurse she wanted to be dead, but staff did not hold an ACCT review to review her risk and ensure they gave her appropriate support. In the early evening, the woman threw very hot water into an officer's face.
5. The next day, 16 May, two members of the mental health in-reach team assessed the woman as fit to face a disciplinary charge of assaulting the officer. Although her segregation safety assessment indicated that segregation was inappropriate in her circumstances (including an imminent assessment for transfer to a secure mental health unit), they overrode this and approved segregation. They thought that the woman had insight into her behaviour and she had no psychotic symptoms. The assessors considered that the segregation unit environment was quieter and might help the woman sleep. No one recorded in the ACCT document, the exceptional reasons to hold a prisoner at risk of suicide and self-harm in the segregation unit.
6. The disciplinary hearing for the assault on the officer started shortly afterwards. The adjudicator adjourned it and referred the matter to the police. The woman remained in the segregation unit after the hearing and officers locked her in her cell. An officer checked her at 11.37am and saw her sitting in her cell. She told the officer she was okay. At 11.50am, another officer

found the woman collapsed on her bed with a plastic bag over her head. She was unresponsive and staff and paramedics' efforts to resuscitate her were unsuccessful.

7. The investigation found that the woman did not get sufficient support from trained mental health staff and there was a general lack of input from mental health staff into the prison's in-patient unit. There is a need to improve communication, information sharing and planning between healthcare staff, specialists and uniformed staff about women's care and their risks. We are also concerned that the woman was segregated although she was being managed under suicide and self-harm prevention procedures and waiting for an imminent assessment to determine whether she should go to a secure mental health unit. There were a number of shortcomings in the ACCT procedures. We make four recommendations about mental health provision, the use of segregation and ACCT procedures.

THE INVESTIGATION PROCESS

8. The investigator issued notices about the investigation to staff and prisoners at HMP Peterborough, inviting anyone with information to contact her. No one responded.
9. The investigator went to Peterborough on 23 May and met senior managers, including the Director, and the prison's family liaison officers. She visited the in-patient unit, reception and the segregation unit – known at Peterborough as the separation and care unit.
10. NHS England (East of England Team) commissioned a clinician to review the woman's clinical care. The investigator and the clinical reviewer interviewed 18 members of staff at Peterborough during the investigation, some jointly. The investigator gave the Director initial feedback about the preliminary findings.
11. We informed HM Coroner for Peterborough of the investigation, who gave us a copy of the post-mortem report. We have sent a copy of this report to the Coroner.
12. One of the Ombudsman's family liaison officers contacted the woman's family to let them know about the investigation. They did not identify any specific concerns they wanted the investigation to consider.
13. The woman's family received a copy of the draft report. They did not make any comments. NOMS also provided a response and, as a result, we have added a paragraph to the investigation process section of this report. We have also amended the wording of the first recommendation for clarification.

HMP PETERBOROUGH

14. HMP Peterborough is a local prison privately operated by Sodexo Justice Services. It holds both men and women in separate sides of the prison. It has a twelve-place mother and baby unit and 24-hour health care provision. Cambridge and Peterborough NHS Foundation Trust provides a seven-day mental health service.

HM Inspectorate of Prisons

15. Her Majesty's Inspectorate of Prisons (HMIP) began an unannounced inspection while we were at Peterborough interviewing staff as part of our investigation (June 2014). We shared with them our main findings and concerns.
16. Inspectors criticised the inpatient unit staff (both clinical and custodial) for their lack of mental health knowledge and awareness and believed the mental health in-reach team staff did not provide a robust enough presence and input into the management of the women there. The inspectorate considered that the purpose of the inpatient unit, which held some women with mental health problems was unclear and some were placed in the segregation unit as there was no suitable alternative.
17. Inspectors found that the ACCT register indicated that eleven women had been held in segregation while subject to ACCT procedures in the previous five months. The exceptional circumstances to justify holding a woman at risk in segregation were not always evident in these cases. Although staff offered some good support to vulnerable women, there was no specialist provision for those with a combination of complex needs and challenging behaviour.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. The IMB annual report for 2012 – 2013 said that healthcare provision at Peterborough was improving. The mental health in-reach team had a good record of transferring patients who need a hospital environment rather than prison, but Sodexo's own clinical health audit had found that a lack of communication and documentation by the mental health in-reach team had affected prison staff's ability to manage those with difficult and complex needs. The IMB was concerned that prisoners with mental health issues continued to be held in the segregation unit, because of a lack of more suitable accommodation in the prison and in the community.
19. In their response to the draft version of this report, the prison pointed out that the IMB at Peterborough had issued a report for 2013-14. In the section about the segregation, care and separation and close supervision units, the IMB said that they remained concerned that prisoners with mental health issues were accommodated on the units due to lack of more suitable

accommodation elsewhere. They also reported that the communication issues in the mental health team had been resolved and there was good communication, especially for prisoners with complex needs.

Previous deaths at Peterborough

20. The woman's death is the third of four self-inflicted deaths at Peterborough since 2009. The other prisoners were men. In the two investigations already completed, we identified concerns about the management of ACCT procedures and some aspects of the mental health in-reach service.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a care-map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

22. The woman had a history of frequent admissions to mental health units since 2000 and a diagnosis of emotionally unstable personality disorder. She had sometimes behaved violently towards others, including mental health staff. In July 2013 and early 2014, between several hospital admissions when she had had continuous suicidal thoughts and had taken overdoses of medication, the woman lived in a community based rehabilitation unit for people with enduring mental health problems. She then moved to supported housing (independent living with support from mental health staff).

2014

23. On 14 April 2014, while an inpatient at Bassetlaw Hospital, the woman was charged with arson for setting fire to a mattress and criminal damage to a chair. She pleaded guilty at the initial hearing on 24 April at Nottingham Magistrates' Court and was granted bail, provided she continued to reside at the hospital and did not behave in a way which would put other patients or staff at risk.
24. On 2 May, the woman took an overdose of paracetamol, threatened a member of hospital staff with a shard of broken glass and threatened to kill another member of staff. On 11 May 2014, she damaged a pool table at the hospital and the police arrested her for criminal damage. After a night in police custody, she appeared at Mansfield Magistrates' Court the next morning. The police had completed a risk assessment and 'exceptional risk' form, which highlighted the woman's suicidal tendencies and mental health problems.
25. The Criminal Justice Liaison Mental Health Service faxed a report to the court about the woman's past psychiatric history and stated that she could not return to Bassetlaw Hospital, because of her risk of harming patients and staff and said that her bed had been allocated to another patient. It noted that the woman wanted to be in a secure mental health setting, had a significant history of suicidal behaviour and stated every day that she wanted to die. She had also said that she would do whatever it took to go to prison. The mental health service recommended close monitoring for four weeks.

12 May 2014

26. The woman appeared in court for arson and two counts of criminal damage. The court remanded her to prison custody, pending an interim hearing and report about her medical condition. The woman had not been in prison before.
27. On the afternoon of 12 May, the Criminal Justice Liaison Team sent a 22-page fax to each of three departments at Peterborough - healthcare, reception and the mental health in-reach team. It included the names and telephone numbers of staff who had looked after the woman and included the following:

- The woman's past psychiatric history, her situation immediately before going into prison and seven hospital admissions in the previous year.
 - Under risk to self, it stated – “significant history of exhibiting suicidal behaviours by various methods including ligation/lacerations. Threats of violence and arson. Recent overdose in March 2014. Unpredictable and impulsive. Homelessness. She reports on a daily basis that she wants to die”.
 - Under risk to others, it stated that the woman had a history of violent impulsive acts and had made recent threats to staff and patients on the ward. She had set fires on numerous occasions.
 - A Wellness and Recovery Plan completed on 13 April 2014. This included a statement from the woman that she wanted to move to a secure unit for her own safety and the sake of her children.
 - A care plan dated 18 April 2014, which said the woman struggled to express her feelings and that this could lead to her becoming angry and frustrated, which then impacted on her mood. Various things were identified to help the woman including one to one sessions with staff twice a day, art and craft activities, music and keeping in touch with her family.
 - A set of multidisciplinary notes from 9 to 11 May, highlighting her behaviour, views on going to a more secure unit or prison to “maintain her own safety and that of others” and the alleged offences.
 - An email exchange between the Criminal Justice Liaison Team and a psychiatrist, about the appropriate place for the woman on 12 May. They agreed that prison might represent the most reasonable short-term option. The psychiatrist emphasised that the receiving prison should be informed of the woman's “extensive history of suicide attempts and deliberate self-harm” and that the “recent fires were in the context of wanting to end her life”.
28. The woman's person escort record (PER, which accompanies prisoners on all journeys between prisons, police stations and courts and should include information about a prisoner's risks) noted a police national computer (PNC) marker for suicide and self-harm. This referred to an attempted paracetamol overdose and an attempted drowning in 2005 and to psychotic phases, during which the woman might cause harm to others in 2003. Other health risks listed included asthma, hepatitis C and paranoia. She left court at 5.10pm, and arrived at Peterborough at 7.25pm.
29. The woman was on a number of medications for physical ailments, as well as lofepramine (an antidepressant) topiramate (a mood stabiliser), clonazepam (a benzodiazepine drug used as a sedative), and aripiprazole (an antipsychotic).

30. A healthcare assistant completed a first reception health screen. She had seen the fax from the Criminal Justice Liaison Team. The woman had cut her arms and legs in the previous few days and showed them to the healthcare assistant. The woman said that she had no concerns about her physical health but said she had mental health problems and had been in prison before. (In fact, this was her first time in prison.) The healthcare assistant recorded that the woman was a serious self-harmer who used ligatures as well as cutting herself, but she had been quiet, polite and pleasant during their interview. The healthcare assistant thought she had seen a suicide and self-harm warning form from the escort contractor, but we have been unable to find one. In view of the information provided and the woman's quietness, the healthcare assistant was worried about her, as she had been told to be extra vigilant of those who are very quiet.
31. A doctor assessed the woman at 7.50pm. The doctor had also seen the detailed fax about the woman and recorded some information in SystmOne (the electronic medical record used in prisons) about her admission to psychiatric units. He thought that the woman's aggression must have been quite severe for the mental health unit to have called the police. However, she presented as calm, relaxed and composed. That had made him nervous about the extent of her mental health problems and what the prison might have to deal with. As her history did not match her immediate presentation, the doctor admitted the woman to the prison's healthcare centre. He re-prescribed her medication, except for clonazepam and aripiprazole, as the medications she had with her were not labelled and he wanted to confirm her prescription with Bassetlaw Hospital first. After a discussion with the doctor, the healthcare assistant opened an ACCT plan and set two observations an hour.
32. At 8.30pm, the woman telephoned her mother from the prison reception area. She told her mother what had happened that day and explained she was in Peterborough prison and was going to the prison's healthcare centre. She slept until about 3.00am. For the rest of the night, an officer noted that she was sitting on her bed, looking out of the window or watching television.

13 May 2014

33. On 13 May, a prison custody officer explained to the woman basic information she needed to know about how things worked in prison. The officer described her as quiet when they first spoke, but she then became more talkative. The officer said she appeared quite flat and there was no emotion in her voice.
34. At 8.50am, the officer interviewed the woman for an ACCT assessment. She noted that the woman's main concern was about her medication and she also spoke about paranoia and hearing voices. The officer had no background information and had not seen the detailed fax, so based the assessment entirely on what the woman told her.

35. The woman told the prisoner custody officer that she heard voices, sometimes a good voice and other times a bad one. She said she had not recently self-harmed (although she had cut herself just before she arrived at the prison) but had previously tried to end her life. She said she was anxious and had not slept well. She sometimes had suicidal thoughts, although she had made no actual plans to carry them through. Her reasons for living were her mum and children, who were all very supportive. The officer noted that she became quite animated when talking about her family.
36. Overall, the officer was concerned about the woman. She wrote in the section listing the triggers and warning signs 'anxiety / paranoia' and 'voices in head'. Some other things had already been written that night – 'severe mental health problem', 'prolific self-harmer' and 'not been in prison before'.
37. Another GP for women prisoners, reviews all patients in the healthcare centre each weekday morning. Every Thursday, a member of the mental health in-reach team also attends. The GP telephoned Bassetlaw Hospital and confirmed the woman's prescription of aripiprazole. He saw her at 11.05am and noted that she appeared calm and relaxed. The GP prescribed clonazepam and aripiprazole.
38. At 11.30am, staff heard shouting from the woman's cell and went to see her. She accused them of talking about her. Two officers assured her that they were there to help her and no one was talking about her. The woman was angry and said that everyone told her that. She became tearful and then calmed down.
39. The ACCT case manager chaired the first ACCT case review with a nurse from the mental health in-reach team and the prisoner custody officer who had interviewed the woman for the ACCT assessment. The case manager had not seen the fax about the woman's mental health background but the nurse had. At the review, the woman said that she had harmed herself the previous night by making superficial cuts to her legs with a broken pen. She said she harmed herself to relieve stress and often thought about suicide when she was extremely stressed. She reported that she had suicidal thoughts at that time due to paranoia and voices in her head, but said she did not want to act on them. She thought someone was going to hurt her and felt scared. She also felt stressed and tired because she was not sleeping well. The case manager told the woman she could trust her and talk to her if she wanted to. When asked what support the staff could offer her, the woman said that she liked criss-cross, word searches and reading. She agreed to tell staff if she self-harmed. The case review assessed her risk as 'raised'. They agreed to maintain the level of observation at two an hour and that staff should have and record three conversations with her each day.
40. The case manager completed the caremap and listed the following issues: mental health issues (an assessment was planned that afternoon); long history of self-harm (the woman was to talk to staff when she felt stressed); stress and anxiety (word searches, puzzles and the library were listed) and videolink court appearance (the mental health team were to decide if the woman was fit

for the hearing on 29 May). After lunch, the officer who attended the first case review gave the woman a colouring pack, pencils, Sudoku and word searches.

41. A nurse carried out a mental health assessment at 3.00pm. The woman told her she was a prolific self-harmer and disclosed past ligaturing and overdose attempts. She said that she used self-harm to cope or when she was feeling suicidal. She spoke about her self-harm on 11 May and said she felt like self-harming at the time, but kept herself distracted from listening to the voices. The woman said she was scared and anxious about being in prison and that the voices got worse when she was stressed.
42. At 6.50pm, the woman tied a ligature made of torn clothing around her neck and pressed the cell bell to call staff. Two officers removed the ligature but the woman did not want to talk about what had happened. A nurse checked her and noted a red mark to her neck but her breathing was spontaneous breathing and she had a good colour.
43. The woman asked the staff to take the television out of her cell, as she thought she might damage it. They gave her a stress ball. After this, she lay on her bed and asked the night officer for a light for her cigarettes every hour or so.
44. At 12.29am, the woman asked the night officer for the Samaritans phone (a cordless phone used to allow prisoners to call the Samaritans from their cells). Another prisoner in the unit had it at the time, and she had to wait until it was free. Half an hour later, when the officer gave it to the woman they found the battery was flat so she was not able to use it.
45. At around 1.00am, the woman told the night officer she had tied a ligature around her neck. He removed it through the door hatch and the woman said she did not want any treatment. The officer informed the orderly officer and a nurse went to see the woman, but she was asleep by that time so they did not wake her. The night officer noted in the staff observation book that there would need to be an ACCT review the next day. The rest of the night passed quietly and, in the morning, the woman told the officer who had done the ACCT assessment she was feeling okay. The staff put the television back in her cell.

14 May 2014

46. The woman refused her morning and lunchtime medications on 14 May. At 9.00am, she started banging on her door, shouting and throwing her chair about. She was abusive, swore at staff and told them not to come near her. She asked staff to take her television out of her cell again. She became calmer for a while, but then resumed her earlier behaviour. Half an hour later, she made scratches to her wrist with a broken piece of plastic. She refused treatment and was verbally abusive to the staff.
47. At midday, the staff held an ACCT case review in the woman's cell as she refused to come out. The same case manager and officer who had attended the first ACCT review were present. The case manager had tried to contact

the mental health in-reach team to invite someone to attend the review, but there was no response and her calls went straight through to the voicemail. (The mental-health in reach team is based in another part of the prison.) The woman told them she was refusing to take any medication because they were trying to poison her. She did not want to engage with staff and said she heard voices telling her what to do. The case manager wrote that the woman was “extremely paranoid”. The woman did not say she wanted to die, but did not want to speak to staff at the time and had paced up and down her cell. The case manager and the officer assessed her level of risk of suicide and self-harm as high and increased the frequency of observations to four an hour.

48. In the afternoon, the woman appeared to calm down a little. She went to the healthcare centre day room and took a shower, but did not want dinner. At 5.45pm, an officer saw some toilet tissue on the floor of her cell with blood on. The woman said she had tried to choke herself and that she “couldn’t take it anymore”. She did not want to talk about why she had done it. A nurse reviewed her and decided no further treatment was required. She did not want to aggravate the woman further and left the cell when the woman said she did not want to speak to her. The officer stayed with the woman for a while and said that she was upset and tearful, but felt a bit better. She removed the rest of the toilet roll and told the woman she could ask for some as often as she needed it. No one informed the night manager of this incident of self-harm and no one considered whether to hold a further ACCT case review, in the light of the incident.
49. Just after 8.00pm, the woman told the night officer she was in pain. At 10.00pm, the nurse gave her some medication. (We assume this was paracetamol, but there was no entry in the clinical record to indicate what medication or how much the nurse issued.) The ACCT records the woman received two paracetamol at 4.56am. The woman was awake at various times during the night and the ACCT records at various times, that she was reading, drinking tea and smoking cigarettes.

15 May 2014

50. On 15 May, the GP who saw the woman on 13 May recorded in SystmOne that he had seen the woman and discussed her with the mental health in-reach team. He noted she was “very challenging” and “seems to be quite volatile”. A nurse from the mental health in-reach team said they were gathering more information from another NHS healthcare trust about the woman. He and the GP decided to do a sharing of risk form so that prison staff would have access to more information about the woman.
51. At 10.10am, the woman harmed herself by putting toilet paper down her throat. A nurse went to see her, but the woman did not want anything to do with her. She told the nurse that she had done it because “I just want to be dead”. As it was clear she did not want to speak to her, the nurse asked whether she would speak to anyone else, but the woman said she just wanted to be left alone.

52. Staff did not hold an ACCT review to consider whether the level of observations needed to be changed and whether the woman needed additional support. This was the second time the woman had tried to choke herself on tissue paper in the previous 24 hours, which was a different method of self-harm from her previous overdoses, ligatures and cutting.
53. The woman told an officer that she had wanted to die because nobody cared about her. During their discussion, she told the officer her children were at university and she seemed to brighten up when she was talking about them. The officer offered to help her use the prisoner telephone system to call them and later gave her the forms for visitors and for using the telephone. The woman told the officer she did not want any association time that afternoon and asked to be locked in her cell. She stayed in bed and at 3.07pm, when an officer asked how she was, she became angry and swore at the officer.
54. A nurse from the Mental Health In reach Team completed the sharing of risk information form in response to the joint GP ward round that morning. She did not go to see the woman, but used the information in the detailed fax and from her first meeting with the woman two days earlier. The form gave brief information about her time in mental health units and that she had been an in-patient before coming to prison. It referred to her long history of self-harm and that she became paranoid when stressed (which exacerbated her self-harm). Her threats of violence towards self and others and setting fires were also listed as risks. Possible protective factors were her family and that she had told nurses at Bassetlaw Hospital that she wanted to go to prison.
55. The first point on the management plan was to keep the woman safe from herself and said that anything which she could use to harm herself had to be removed from her cell and person. (It does not appear that any action was taken as a result.) The nurse noted that staff needed to be aware that the woman had previously attacked others when she was feeling paranoid. Staff needed to encourage her to take her medication. The woman was to remain on ACCT support and staff should review her observation levels if her self-harm increased significantly. The sharing of risk form said the woman could be moved to the separation and care unit (segregation unit) if she became violent towards others. The nurse noted on SystmOne that the community mental health team in Nottingham had sent a referral to a Secure Unit about a possible hospital transfer for the woman. The secure unit team were meeting the next day to discuss the referral.
56. When interviewed, the nurse said the purpose of the form was to share the woman's known risk factors with other staff, such as the officers who worked in the healthcare centre who would not have had access to the woman's healthcare records. The form should have been kept inside the front of the ACCT document so that everyone dealing with her would have been able to see it. A psychologist in the mental health in-reach team told the nurse she would put the completed form in the ACCT, but it is not clear what happened to it. The psychologist told us she definitely put the form in the ACCT document. However, it was not in the ACCT when the investigator checked

the original sealed copy at the prison and no other member of staff remembered seeing it among the ACCT papers.

57. Two nurses carried out the medication round that day, but the woman's two-page prescription chart was incomplete so it was not clear whether she had received her medication. The healthcare manager told the investigator that the woman had received her medication but the nurses had not recorded this and signed the chart. The manager said that nurses had subsequently received further training about completing prescription charts.
58. At 5.00pm, the woman collected her evening meal from the servery, which was directly across the corridor from her cell. For no apparent reason at the time, she threw a cup of very hot water into an officer's face. Staff charged the woman with a disciplinary offence of assaulting the officer.
59. When a nurse asked the woman why she did it, she replied, "Because I did". The nurse thought she seemed agitated and very different from that morning. She considered that the woman was very unstable and seemed not to care about her actions. The woman stayed in her cell and slept, on and off, until 4.30am. The night officer said she was in a bad mood when he tried to speak to her and did not want to talk.

16 May 2014

60. At around 6.00am on 16 May, the night officer saw the woman crying. Shortly afterwards, she told him that the prison clothes staff had given her had fleas and she had bites. He advised her to see the GP and said that the day staff could sort out new clothes and bedding. At 7.45am, when asked, she told a senior prison custody officer that she had no remorse for what she had done the day before. At 8.50am, she asked for some toilet roll and asked why she could not have the whole roll. The officer told her that because of her self-harm, she could have only a few sheets at a time for her own safety.
61. The deputy head of healthcare told the Director that healthcare staff would assess whether the woman was fit to be segregated and to understand the adjudication (prison disciplinary) process. The GP said he had no medical concerns about the woman and the deputy head of healthcare arranged for the mental health team to assess her.
62. At 10.40am, a nurse and a psychologist from the mental health in-reach team, spoke to the woman for 20 minutes as part of the assessment. They said the woman engaged very well and had reflected on the previous day. She said she was sorry for assaulting the officer and would apologise to him when she next saw him. Her explanation was that she thought the officer had been talking to other people about her.
63. The woman reported poor sleep, reduced appetite, paranoia and fluctuating moods. She said she did not feel suicidal or have any intention to harm herself that day, but said she had trouble coping. She was unhappy that her medication had changed in recent weeks and thought this was the reason why

she had not been able to sleep. The woman said her self-harm in prison had been impulsive. The note of the meeting indicated that the woman's mood could change very rapidly and unpredictably and that she could be very impulsive. The nurse said there was no evidence of any psychotic symptoms and the woman seemed quite motivated and positive about working with them. However, she "appeared blunted emotionally and rather detached, tended to stare with limited eye contact". The nurse and the mental health team psychologist considered that staff should continue to observe the woman four times an hour. They noted that she had said she would smash and swallow things and that there should be reduced access to anything that she could use in this way.

64. The nurse agreed that the woman could move to the segregation unit as it was a lower stimulus environment, less noisy than the healthcare centre and he felt she would sleep better. He did not consider the woman would be adversely affected, clinically, by being segregated. He noted that she had capacity and full insight into her actions. The mental health staff fed back their views to the deputy head of healthcare. The nurse spoke to the GP about the woman's medication and he agreed to prescribe quetiapine (an antipsychotic which the woman had previously taken) in place of aripiprazole.
65. Staff put a note of the in-reach assessment in the woman's healthcare daily care plan and SystmOne. However, no one wrote anything in the ACCT document and no one passed the daily care plan (a healthcare document) to segregation unit staff. The only document the segregation staff could access was the ACCT plan.
66. At 11.05am, two officers took the woman to the segregation unit. Five minutes afterwards, she was put into cell two, another checked on her. She was sitting on the bed and nodded in acknowledgement when asked if she was okay.
67. A nurse told the manager who would conduct the disciplinary hearing that a meeting in Nottingham that day would consider whether the woman should transfer to a secure unit and that she had recently tried to choke herself with tissues. A senior prisoner custody officer went to the woman's cell with an officer at 11.18am and explained the adjudication process to the woman. While they were there the senior prisoner custody officer took away the toilet roll from the cell. He said that the woman maintained good eye contact and did not look unduly concerned.
68. The manager who was going to conduct the disciplinary hearing and the nurse discussed the woman's observation levels and agreed that staff should continue to monitor her four times every hour. They did not hold an ACCT case review, which they should have done either immediately before the woman left the healthcare centre or as soon as she arrived in the segregation unit. The nurse completed an initial segregation health screen and judged there were no healthcare reasons not to segregate the woman at that time. The manager also completed a mental health assessment form to agree that the woman was fit for segregation under Prison Rule 45 (Good Order or Discipline). No one wrote anything in the ACCT document to explain what the

exceptional reasons were to hold the woman, who had been assessed as at risk of suicide and self-harm, in the segregation unit.

69. At her disciplinary hearing at around 11.24am, the woman pleaded guilty to assault. Because of the perceived seriousness of the charge, the adjudicator decided to refer the charge to the police and adjourned the hearing. He described the woman as slightly withdrawn and that she kept her head down, avoiding eye contact. The manager (who conducted the adjudication) authorised her continued segregation but gave no exceptional reasons. An officer said the woman showed no emotion during the adjudication and described her as “almost vacant”.
70. At 11.30am, just before the food trolley arrived, the woman pressed the cell intercom button and asked for a toilet roll. The officer checked with the senior prisoner custody officer and they gave her enough to use the toilet once. The officer told the woman that the senior officer would talk to her after lunch. The woman nodded and said okay. Officers then started unlocking the women in the segregation unit for lunch. Cell one was first and then it would usually have been cell two, the woman’s cell. However, because she had just arrived, her meal had been taken to the healthcare centre. The staff therefore moved on to the other cells first. An officer checked the woman at 11.37am. She was sitting on her chair and nodded that she was okay when the officer asked her.
71. By 11.50am, all the other women in the segregation unit had received their lunch. There was enough food left to offer the woman a choice of meal so an officer went to her cell to ask what she would like. When she looked through the door observation panel she saw the woman lying on the bed, her legs partially off and with a plastic bag over her head. (This was a small bin bag put inside the cell rubbish bins.) The officer called out to the other officer, unlocked the door and went in.
72. CCTV footage of the unit shows that the two officers and the senior officer were all at the cell within 15 seconds. The officer who had looked into the woman’s cell said that some of the plastic bag was inside the woman’s mouth. She radioed for ‘medical assistance’ and put a hole in the plastic bag using her fingers. She shook the woman to try to get a response and pulled the whole bag away from the woman’s head. The other officer described the woman as blue in the face and with no movement. After about 20 seconds, she radioed an emergency medical ‘code blue’ message. The control room called an ambulance, which arrived at the prison gate at 12.02pm.
73. The staff checked for a pulse or signs of breathing, but there were no signs of life. One of the officers described the woman’s body as very cold. The senior officer said the woman’s face was blue and she had urinated. Another officer began chest compressions.
74. The designated response nurse was in a clinic a few metres away when she heard the call for medical assistance. Just as she arrived at the entrance to the unit, she heard another radio message stating it was a code blue emergency. The response nurse got to the cell just over a minute after the

woman had first been found. She asked someone to get a defibrillator and the emergency grab bag and to call the GP. The nurse said an officer was doing chest compressions when she arrived. No one told her that the woman had been found with a bag over her head; because of this she was not clear why the woman had stopped breathing. As she knew that the woman had previously tried to swallow tissues, she thought she might have put something down her throat. The nurse tried to get a response from the woman and described her as cold, with fixed pupils. She then took over the chest compressions.

75. Another officer who was trained in cardiopulmonary resuscitation got to the cell a minute after the nurse and saw her doing chest compressions. He put his resuscitation face mask over the woman's mouth, ready to begin rescue breaths. The nurse said breaths were unnecessary at that time and asked again for the grab bag, which contained the defibrillator. The emergency equipment arrived at 11.54am. The nurse applied the defibrillator but this found no shockable heart rhythm. Another nurse arrived and assisted the initial response nurse who began giving rescue breaths. The GP arrived at 11.56am. He said the woman had no pulse, was not breathing and her pupils were fully dilated. An officer got the oxygen cylinder ready. The GP found a Guedel airway in the emergency grab bag and put it in the woman's throat.
76. Two ambulance technicians reached the cell at 12.05pm and a first response car with two paramedics arrived a few minutes later. They and the prison staff continued to try to resuscitate the woman. They moved her to a wider area of the unit to allow staff and their equipment more room. The paramedics continued emergency treatment, including intravenous injections, but at 12.41pm, one of the paramedics pronounced the woman dead.
77. The prison Director held a debrief meeting at 1.00pm with the staff involved in the emergency response. The meeting discussed whether it would be helpful to have an emergency grab bag and defibrillator in the segregation unit. The Director ensured that the staff were appropriately supported. Staff reviewed all prisoners who were being managed under ACCT procedures and all women patients in the healthcare centre in case they had been adversely affected by the news of the woman's death. As a precautionary measure, the Director instructed staff to remove all plastic bin bags from cells in the healthcare centre and segregation unit.

Liaison with the woman's family

78. Two prison family liaison officers left Peterborough quickly, at 12.50am, and went to the woman's mother's home. The journey took just over an hour and a half. The woman's mother was not there when they first arrived, but they spoke to her over the telephone and she came home. The two family liaison officers broke the news of the woman's death and suggested she invite other family members around for support.

79. The woman's family asked to visit the prison and Peterborough arranged this a few days later. The prison offered financial assistance towards the funeral in line with national policy.

Post-mortem report

80. A Home Office pathologist carried out a post-mortem examination on 21 May 2014. He concluded that the cause of death was plastic bag asphyxia. A blood test showed the presence of drugs that were consistent with the woman's prescribed medication.

ISSUES

Mental healthcare

81. The clinical reviewer noted that many of the women in the inpatient unit at Peterborough, including the woman, had complex mental health problems and challenging behaviour. However, the unit had only limited nursing cover and no mental health trained nurses were based there. It was staffed mainly by prison custody officers who were the primary carers. The officers, nurses, GPs and mental health in-reach team did not always work in a co-ordinated way.
82. Despite being the primary carers, the officers sometimes felt excluded from discussions and care planning because of medical confidentiality and there were no protocols for determining what medical information could be shared with them. Although they were expected to use the healthcare daily plan to communicate with and share information about patients, only some nurses and in-reach staff used it. Some said that they did not have a password to log into it. The clinical reviewer was not satisfied that the officers had sufficient training to manage women with complex mental health issues
83. Both the GPs based at the prison said that there was a lack of skills at the prison to deal with complex patients such as the woman and the response of mental and forensic health services was slow. They gave several examples where patients waiting for transfer to a mental health hospital were given no priority as they were viewed to be already in a 'place of safety'.
84. The nurse from the mental health in-reach team assessed the woman the morning after her reception into Peterborough. As the week continued, her mental health deteriorated, but she was not allocated a care coordinator from the mental health team and the nurse did not see her again. No one from the mental health in-reach team saw the woman again until they assessed her fitness for segregation on 16 May. When they were interviewed, mental health staff said that they were waiting for more information about the woman. However, they already had a 22-page fax from the Criminal Justice Liaison Team outlining the woman's mental health history, diagnosis, risks and a recent care plan. They could also have called Bassetlaw Hospital if they needed further information. There was no coordinated care plan to ensure continuity of care for the woman.
85. After three self-harm incidents in 24 hours, the ACCT case manager tried to contact the mental health team on 14 May to get their input into an ACCT case review but she was unable to get hold of anyone. The review went ahead without any mental health team representative present, although the woman's mental health was fundamental to her risk of suicide and self-harm and the support she needed.
86. Despite the woman's complex and extensive history of mental health problems, no one referred her to a consultant psychiatrist. The clinical reviewer indicated that as she had transferred from a mental health ward, he

would have expected a consultant psychiatrist to have reviewed her care at the earliest opportunity. A locum psychiatrist was in the prison that week, but no one asked the psychiatrist to see and assess the woman as an emergency case. The clinical reviewer's view was that this was a major omission.

87. The clinical reviewer concluded that there was no clinical leadership in the woman's care and, despite her deteriorating state, no one showed any sign of urgency in recognising that she needed more care than was available in the in-patient unit. The clinical reviewer judged the woman's mental health care at Peterborough to be poor. In the healthcare centre at Peterborough, her care was principally from prison custody officers, with some input from GPs, mental health in-reach and a nurse manager. She did not have routine access to mental health trained staff, except on the two occasions when she saw members of the in-reach team.
88. Had the woman been in the community, mental health trained staff would have provided her care. On this basis, the clinical reviewer judged her mental health care was worse than she would have had in the community as she received a lesser standard of care at Peterborough and was not referred to a psychiatrist. We note that the recent inspection of the women's prison found that the purpose of the inpatient unit at Peterborough was unclear and that more investment was needed in mental health training for staff. We make the following recommendations:

The Head of Healthcare should ensure that women prisoners with complex and long-standing mental health problems and are under the care of a psychiatrist when they arrive, have a named care coordinator and are referred immediately to the mental health in-reach team and a psychiatrist for an urgent assessment when they arrive in prison.

The Director and Healthcare Manager should ensure there are sufficient trained mental health staff to meet the needs of women in-patients in the healthcare centre.

The decision to segregate the woman

89. Prison Service Order 1700 details the procedures to follow when segregating prisoners. A qualified healthcare professional (nurse or doctor) complete a Segregation Safety Algorithm (safety assessment) for all segregated prisoners. The purpose is to take a snap shot assessment of a prisoner's mental health when deciding whether to segregate them. The safety assessment was designed in response to a European Court of Human Rights judgement in 2001, about the imposition of segregation on a mentally unwell prisoner who self-harmed. The aim is to exclude very mentally unwell, suicidal prisoners from segregation, in all but the most exceptional of circumstances.
90. The assessment has a flow chart of four questions. Depending on the answer to each question the chart concludes either "no healthcare intervention at this

time” or “there are healthcare reasons not to segregate at this time. Discuss with health team”.

91. The four questions are:
1. Is the prisoner awaiting transfer to / being assessed for a bed in an NHS secure setting? A ‘yes’ answer leads to ‘healthcare reasons not to segregate’. In the woman’s case, the answer was ‘yes’ as a secure unit was assessing her that day.
 2. Has the person self-harmed in this period of custody / are they on an open ACCT plan or is the person currently taking any antipsychotic medication? If the answer is yes, another box asks whether the assessor thinks the prisoner’s mental health will deteriorate significantly if segregated. There was no response to either question on the woman’s form. She had self-harmed, was on an ACCT and was taking antipsychotic medication.
 3. Does the prisoner show signs of being acutely unwell (eg. psychotic / withdrawal from drugs / significant physical injury) at the present time or within 4 weeks of the start of detox / stabilisation? No response was indicated on the form.
 4. Do you think that the prisoner will be able to ‘cope’ with a period of segregation? Both the yes and no boxes were circled on the woman’s form.
92. The nurse who completed the assessment, signed the box “no healthcare intervention at this time”. By doing this, he overrode the conclusion, as question one is unequivocal that ‘yes’ results in healthcare reasons not to segregate. The remaining questions on the form permit the medical assessor to interpret their meaning and make a judgement about the prisoner’s mental health. We do not consider that he completed this part of the assessment correctly.
93. The second page of the initial segregation health screen states prisoners on an ACCT must be located in the segregation unit only in exceptional circumstances, where there is such a risk to others that no other location is suitable and when these other options have been tried or are considered inappropriate. The manager who conducted the disciplinary hearing said he had specifically spoken to the nurse about this and relied on his expert medical opinion when deciding whether it was appropriate to segregate the woman. As the nurse was content, the manager supported this view.
94. While the manager ensured that mental health team was content for the woman to be segregated, he was the person responsible for segregating the woman and his responsibilities go beyond checking that healthcare staff have no objections to segregation. It was his responsibility to make a judgement about segregating the woman taking into account all the information available and to satisfy himself that, as a prisoner being managed under ACCT procedures, all other options had been considered and that there were

exceptional reasons to justify the woman's segregation. Ultimately, it is an operational manager, not the mental health team who is responsible for authorising segregation. The manager did not specifically assess the most appropriate location for the woman or consider whether she could have remained in the healthcare centre, possibly under a more restricted regime. He did not consult the ACCT case manager about her opinion as to the suitability of the woman going into segregation.

95. The psychologist said she believed her remit when speaking to the woman was about whether she had 'capacity', whether she had been responsible for her actions the night before and whether she was fit for adjudication. Although she and the nurse considered the possibility of segregation, she had presumed the decision to keep the woman there would have been made after the adjudication. There appears to have been a lack of clarity about the reasons for the mental health assessment; deciding whether the woman had capacity to understand the assault charge is very different from assessing whether she could safely leave the healthcare centre and transfer to the segregation unit.
96. The deputy head of healthcare said the decision to segregate the woman was not based solely on her presentation on the Friday morning when the psychologist and nurse had assessed her, but on her background history as well. He felt all historical and current risk factors had been taken into account. The deputy head of healthcare said the nurse's professional opinion was that the segregation unit would have been better for the woman than healthcare because it was a lower stimulus environment. (Segregation unit staff said that this would depend on who was in the unit at a particular time. Some segregated women bang on their doors constantly.)
97. Prison Service Instruction (PSI) 64/2011, which covers safer custody, states:

"prisoners on open ACCT plans must only be located or retained in segregation units only in exceptional circumstances. The reasons must be clearly documented in the ACCT plan and include other options that were considered but discounted".
98. The PSI also says, "The ACCT plans must be reviewed as soon as it is practicable before location in the segregation unit or immediately thereafter". No such case review was held for the woman and there are no documented reasons in the ACCT plan to explain the decision to move her to the segregation unit. (The reason given for segregation was to assess her risk to others. It is not apparent why this could not have been done in the healthcare centre.) In fact, it is unclear from the ACCT document that the woman had moved to the segregation unit. The meeting between the nurse, the psychologist and the woman should have been followed immediately by an ACCT case review, chaired by the deputy head of healthcare (in the case manager's absence) and attended by the mental health team, GP, an officer and ideally, someone from the segregation unit. (We make a recommendation about this issue in the section on suicide and self-harm monitoring.)

99. Staff told the investigator it was not unusual to segregate women prisoners being managed under ACCT procedures (except those who being observed constantly or five times an hour, who remain in the healthcare centre). They said it was less common, although not rare, for mentally unwell prisoners (ie those under the care of the mental health team) on ACCTs to be segregated. They therefore did not find it particularly unusual or concerning that healthcare staff had assessed the woman as safe to be segregated and prison staff rely on the expert judgement of the mental health in-reach team. One officer said she thought women were more likely to be taken out of the segregation unit for physical health reasons, such as withdrawing from drugs, than for mental health reasons. The recent inspection of the prison found that too many women at risk of suicide and self-harm were segregated without any exceptional reasons recorded to justify this.
100. Staff at Peterborough indicated that it would have made little difference to the woman's management whether she was segregated or in the in-patient unit. In either location, she would have been subject to a three-officer unlock and not allowed to associate with other women because of the risk of her assaulting them. While to a certain extent this could be the case, this is not a justification for ignoring Prison Service guidelines and mandatory instructions designed to promote safety. There is an important distinction between the two environments - segregation has connotations of punishment and discipline, whereas a healthcare setting should have a primary emphasis on providing care to meet prisoners' health needs, whether physical or mental. The whole purpose of the segregation safety assessment is to prevent people like the woman being held in segregation units.
101. We are concerned that the prison did not appear to regard it as exceptional to place a woman with severe and complex mental health problems in the segregation unit. The decision to segregate the woman that morning is even more difficult to understand as she was being considered for a secure hospital place by a mental health services in Nottinghamshire that day. We make the following recommendation:

The Director and Head of Healthcare should ensure that women prisoners identified as at risk of suicide and self-harm, women with complex mental health problems and women being assessed for transfer to a secure hospital, are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.

Suicide and self-harm monitoring

Triggers and warning signs

102. Three things had been listed on the first page of the woman's ACCT document which deals with triggers and warning signs. These were, 'severe mental health problem', 'prolific self-harmer' and 'not been in prison before'. The ACCT assessment officer added 'anxiety / paranoia' and 'voices in head'.

During interview, she said she felt the purpose of the section was a list of events or feelings that might make the person self-harm.

103. PSI 64/2011 states that this section of the ACCT should be completed at the first case review. It should list events or signs of increased risk that will be watched for and which trigger further action and /or an immediate case review. Examples given include changes in status, further charges, segregation, court appearances and relationship breakdown. (Staff did not hold a case review when two of these suggested triggers affected the woman – moving to the segregation unit and having further charges referred to the police.)
104. We do not think staff completed this section of the ACCT as the PSI intends. The three things that had already been written about the woman were not events that might happen to her, but background risk factors. The latter two were too broad. It would have been impractical to hold a case review each time the woman showed signs of paranoia, anxiety or heard voices.

Responding to acts of self-harm

105. The operational manager who conducted the woman's disciplinary hearing said the orderly officer (a senior person in charge of the day to day running of the prison) does not attend every minor incident of self-harm at Peterborough, but should attend where a prisoner has been found with a ligature. However, staff should complete an incident report form each time.
106. The woman self-harmed on 13, 14 and 15 May. On Tuesday 13 May, she made a ligature of torn clothing and then informed staff. They did not ask the orderly officer to attend. At 1.25am on 14 May, the woman told the night officer she had put a ligature around her neck. He took it off through the door hatch. Staff informed the nurse and orderly officer, but the woman had fallen asleep when the nurse went to see her. The next morning, the woman made cuts to her left wrist, described by the staff as scratches. The case manager held an ACCT review and increased her level of observations. At 5.45pm that afternoon, the woman self-harmed by putting tissues down her throat but there was no ACCT review. At 10.10am on Thursday 15 May, the woman self-harmed by putting tissue down her throat again. Again, there was no further ACCT review to reassess her risk and consider whether she needed additional support.
107. When we interviewed the case manager, she was concerned that staff had not held a case review after each incident involving a ligature. The night orderly officer should at least have carried out a case review. The case manager increased the woman's risk level to high and her level of observations to four per hour when she chaired the ACCT review at lunchtime on Wednesday 14 May.
108. As the case manager was on a training course on 15 and 16 May, she did not do her usual morning checks of the ACCT documents in the healthcare centre. No one else picked up this task or considered whether they should review the woman after she self-harmed on 14 May and 15 May. Both of

these incidents were swallowing tissues, which was a change in the method of self-harm and we consider this should have led to an ACCT case review. This meant that there was no further consideration of the woman's level of risk after the case review of 14 May.

109. The operational manager said first line staff who managed the woman were responsible for telling senior staff when there had been an act of self-harm. The deputy head of healthcare agreed with this view and said the nurse and the officer monitoring the woman should have triggered an ACCT case review if they felt it was needed. The officer said she would have reported it to the orderly officer if she had actually seen the woman putting the tissues in her mouth and it would have been up to the orderly officer, not her, to decide whether to hold an ACCT review.
110. The nurse said she did not consider asking for a case review and another officer said she did not have the authority or responsibility to make the decision, which would be for the case manager to decide, or whoever was covering that responsibility in the case manager's absence.
111. We are not satisfied that Peterborough has a clear process to ensure that the appropriate member of staff considers whether to hold an ACCT case review in response to increasing levels of self-harm or changes in the method of self-harm which might increase the prisoner's risk. This meant that there was no further ACCT case review after 14 May, although there had been significant changes, including further self-harm and a move to the segregation unit.

Communicating information about risk

112. Staff did not always work effectively as a team in the way the ACCT process intends. For example, on Wednesday 14 May, The woman harmed herself four times. Officers recorded each incident in the ACCT document, but did not discuss them with the GP or the mental health in-reach team and neither were represented at the ACCT review that day.
113. The healthcare daily plan contained a comprehensive note of the meeting on 16 May between the woman and the two mental health in-reach staff. It referred to her impulsive behaviour and rapid mood changes. It also listed items to which the woman should have limited access. This was not shared with the segregation unit manager or other staff. When the woman moved to the segregation unit just a short while later, staff made no entry in the ACCT. This meant that staff who were going to be looking after the woman did not see any of the written assessment, nor was there a multi-disciplinary ACCT review when the woman moved to the segregation unit at which this could have been discussed.
114. This failure to communicate information about the woman's risk meant that segregation staff did not make a comprehensive inspection of her cell when they moved her from healthcare. Had they done so, it is likely that the toilet roll, bin bag and other items such as plastic cutlery that she might have used to harm herself would have been removed from her cell.

ACCT ongoing entries

115. The prison custody officers said most nurses in the healthcare centre do not read the ACCT ongoing record or the most recent case review before they see a patient and rely on the medical record. Some nurses we spoke to viewed the ACCT as something for officers and other prison staff to use, rather than for healthcare staff. For example, the nurses do not record in the ACCT when a patient refuses her medication. We consider it is important that this type of information should be recorded in the ACCT and shared and discussed at case reviews, as it might affect the woman's risk.
116. The deputy head of healthcare agreed that nurses should make entries in the ACCT document about conversations and interactions, but not about aspects of medical treatment. The ACCT is a multidisciplinary tool, reliant on teamwork and sharing information to help protect prisoners at risk. While we accept the need for medical confidentiality and the primacy of the medical record for treatment issues, it is against the intention of PSI 64/2011 for nurses and doctors not to read or make entries in ACCT documents to ensure that all prison staff have the information they need about a prisoner's risk. When an ACCT is opened, prisoners usually sign an agreement to allow relevant information affecting their risk to be shared and the woman had given her agreement.
117. The investigation identified a number of concerns about the operation of ACCT procedures at Peterborough and we make the following recommendation:

The Director should ensure staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Ensuring all staff have a clear understanding of their responsibilities in the ACCT process and the need to share all relevant information about risk.**
- **Holding multidisciplinary case reviews when there is an increase in risk or further act of self-harm and that all relevant people involved in a prisoner's care, particularly mental health staff, are involved in the review; where this is not possible advice should be sought and documented as part of the review.**
- **Ensuring that all relevant staff are aware of significant health plans and medical information for managing prisoners assessed as a risk of suicide and self-harm.**
- **Completing ACCT documents fully and accurately; and**
- **Considering all known risk factors, including sharing historical information, when determining the level of risk of self-harm.**

Emergency response

118. The officer who found the woman unresponsive called 'medical response' on her radio and admitted that in her panic, she forgot the correct emergency

code to use. Another officer converted the call to a code blue within a few moments and we are satisfied that this led to no delay.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that women prisoners with complex and long-standing mental health problems and are under the care of a psychiatrist when they arrive, have a named care coordinator and are referred immediately to the mental health in-reach team and a psychiatrist for an urgent assessment when they arrive in prison.
2. The Director and Healthcare Manager should ensure there are sufficient trained mental health staff to meet the needs of women in-patients in the healthcare centre.
3. The Director and Head of Healthcare should ensure that women prisoners identified as at risk of suicide and self-harm, women with complex mental health problems and women being assessed for transfer to a secure hospital, are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.
4. The Director should ensure staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Ensuring all staff have a clear understanding of their responsibilities in the ACCT process and the need to share all relevant information about risk.
 - Holding multidisciplinary case reviews when there is an increase in risk or further act of self-harm and that all relevant people involved in a prisoner's care, particularly mental health staff, are involved in the review; where this is not possible advice should be sought and documented as part of the review.
 - Ensuring that all relevant staff are aware of significant health plans and medical information for managing prisoners assessed as a risk of suicide and self-harm.
 - Completing ACCT documents fully and accurately; and
 - Considering all known risk factors, including sharing historical information, when determining the level of risk of self-harm.

