

**The Death in Custody of
a woman at
HMP Holloway in October 2005**

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

September 2006

This is the report of an investigation into the circumstances of the death of a woman at HMP Holloway on 28 October 2005. She was found hanging in her cell in the life sentence prisoners unit. She was 30 years old.

I extend my sincere condolences to the woman's family and friends for their loss.

The investigation was carried out by two of my colleagues. I would like to thank the Governor of Holloway, and his staff for their help. The Governor's personal actions following the woman's death deserve a special mention.

The woman had arrived in Holloway on 9 September 2005, after being transferred from HMP Styal. She had spent most of her adult life in custody, and at the time of her death had served almost eight years of an indeterminate life sentence for arson. The woman said she had a troubled childhood and was prone to frequent acts of deliberate self-harm. However, with one recent exception at Styal, these usually resulted in minor injuries only. She had been kept subject to special monitoring while at Styal and this monitoring continued upon her transfer to Holloway. I note a sad sentence from the first of the clinical reviews that form part of this report: *"A feature of her personality disorder was mood swings, frequent self-harm episodes and suicide threats and attempts from the age of 13."*

Following her death, it was discovered that the woman had written a lengthy letter to her aunt in which she assessed her life and reached the conclusion that she did not wish it to continue. Staff at Holloway could not have been expected to have anticipated the woman's intentions.

I have made 14 recommendations. One refers to the provision of safer cells. The remaining 13 all relate to health care provision, especially in connection with managing serious clinical incidents.

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Prisons and Probation Ombudsman

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SUMMARY

On 9 September 2005, the woman arrived in Holloway on transfer from HMP Styal. She had been sentenced to an indeterminate life sentence for arson, and had served almost eight years. The woman was 30 years of age.

Just before her transfer out of Styal, she had taken another prisoner hostage. The woman later told a consultant psychiatrist that this abnormal behaviour had occurred when a lot of unsettling things were happening in her life. This included the first anniversary of the death of her grandfather, the suicide of a friend at Styal and the illness of her grandmother. The woman also mentioned that she had been told that the hostage-taking might lead to ten years being added to her sentence.

At Styal, she had been subject to special monitoring through the ACCT (Assessment, Care in Custody and Teamwork) process. (This is the arrangement for monitoring prisoners judged to be at risk of self-harm or suicide.) The woman had reported that she self-harmed as a coping mechanism. It was for this reason that she was subject to special monitoring at Styal and this continued upon her arrival in Holloway.

The woman's records at Holloway contain frequent references to acts of self-harm, but none of these resulted in serious injury. Instead, the injuries were described either as superficial cuts or scratches or cigarette burns. The records also show that her moods fluctuated quite rapidly.

In many respects, 28 October might have seemed like any other day for the woman. She had an argument with an officer in the morning which resulted in her throwing some objects. The officer wanted to place the woman on disciplinary report, but a Senior Officer (SO) suggested a lesser penalty and later that day the woman thanked the SO for her intervention. At about 5.30pm, an Officer made a note in the woman's records that she did not 'seem her high spirited self' that afternoon, but when spoken to by the investigators the officer said that it was not unusual for the woman to be like that.

At just after 7pm, one of the other prisoners complained loudly about the smell of incense being created by the joss sticks that the woman was burning in her room. An Officer asked the woman to keep her door and door hatch closed when burning joss sticks. The woman was upset by this incident as she felt she was being picked on. At about the same time, a Nurse was distributing evening medication and she told the woman not to take any notice of the other prisoners. She also said that she liked the smell. The woman was pleased that the Nurse liked the incense and she told the Nurse that she was happy because she was due to start work in the prison laundry on the following Monday.

Just before 7.30pm, an Officer went back to the woman's cell to check how she was. When he looked through her cell hatch he saw that she was hanging from a ligature tied to the window frame. The Officer radioed a Code Blue alarm to summon emergency assistance and was joined by two Senior Officers. The

Officer supported the woman's body while one of the Senior Officers used an anti-ligature knife to cut the ligature. The officers placed the woman on the floor and, after checking for presence of a pulse, the two Senior Officers commenced attempts at resuscitation.

Healthcare staff also responded to the alarm. The first to arrive was a Nurse and she brought the 'blue bag' containing an oxygen cylinder and other first aid equipment. A Senior Nurse who was acting as Hotel 1 (the senior healthcare responder for emergencies) took five or six minutes to arrive, as she was dealing with another potential emergency situation elsewhere in the prison. Although healthcare staff helped by giving oxygen and using the defibrillator, they did not offer to relieve the two Senior Officers in attempting resuscitation and so the Senior Officers had to continue until ambulance paramedics arrived.

The woman was taken to hospital by ambulance, but all efforts to save her proved unsuccessful and she was declared dead at 8.29pm.

Following her death, one of the other prisoners gave a Senior Officer a seven page letter dated that day which the woman had written to her aunt. The letter shows the woman to have been in high spirits when she started the letter and she mentions her delight in having a job to start after the weekend. However, the woman's mood changes in tone as the letter progresses. Her happiness turns to despair and she informs her aunt that she has decided to take her life.

I have made 14 recommendations. .

INVESTIGATION PROCESS

The investigation was opened on 1 November 2005. Two of my colleagues visited Holloway and met a number of prison staff, including the Governor and Deputy Governor of HMP Holloway, the prison's acting head of healthcare, and a representative from the Prison Officers' Association. My colleagues informed the staff of the nature and scope of the investigation. Notices were issued to staff and prisoners notifying them of the investigation. Sixteen members of staff and two prisoners were interviewed.

Islington Primary Care Trust agreed to carry out separate reviews of the woman's clinical care and treatment while at Holloway. One clinical review, carried out by, a consultant psychiatrist, considered the woman's psychiatric care and treatment. The other clinical review, carried out by a consultant in emergency medicine, considered the response by staff when the woman was found hanging.

One of my Family Liaison Officers, contacted the woman's mother and aunt to inform them of the investigation.

HMP HOLLOWAY

Holloway is a women's local prison located in north London that serves courts throughout the South-East of England. Cells are located in a maze of corridors and spurs.

Holloway holds just under 500 women and is a prison with many diverse functions. Its main role is to hold women on remand or waiting sentence. It also has a Mother and Baby unit, a Young Offender unit that holds girls and young women between 15 and 21 years old and a unit for life sentence prisoners.

On 1 April 2004, Islington PCT took on responsibility for commissioning healthcare at Holloway. It was one of first PCTs to have healthcare commissioning responsibilities in prisons in England.

The woman's death was the third apparently self-inflicted death of a young woman at Holloway since April 2004 when I took over responsibility for the investigation of all deaths in prison custody.

THE WOMAN

The woman was born in the West Midlands on 31 August 1975. She had two half-siblings – an older half-sister and a younger half-brother. Her mother still lives in the West Midlands, as does her grandmother to whom the woman felt particularly close.

The woman reported that she had a difficult childhood. Her parents were said to have had a volatile relationship, leading to separation when she was around 11. The woman was taken into care in 1988 at the age of 12 or 13 as a result of some unsettling behaviour on her part. Following initial assessment, she was returned first to her mother's home and subsequently to her father's. A number of unfortunate incidents, including threats of self-harm and hoax calls to the emergency services, led to her spending more time in children's homes.

In late 1991, the woman was convicted on charges of burglary, theft and criminal damage. Her offending behaviour continued and, in February 1995, she was convicted of arson and recklessly endangering life. The woman was sentenced to five years in a young offenders' institution and was released in July 1997. In September 1997, she committed a further offence of arson for which she was again convicted. A discretionary life sentence was imposed on her with a four year tariff.

The woman spent time at a number of different prisons. Her progress reports at these prisons showed that she continued to have behavioural problems and had difficulty addressing her offending behaviour. The woman was transferred from HMP Styal to Holloway on 9 September 2005.

The woman spoke very fondly about her grandmother, and she had been close to her grandfather before his death in 2004. She also had fond thoughts about her aunt, sister and niece. The woman had pinned many family photographs on the walls of her room at Holloway.

EVENTS LEADING UP TO THE WOMAN'S DEATH

The woman was convicted of arson in November 1997. In light of her offending history, the judge sentenced her to life imprisonment, with a recommendation that her case would not be considered by the Parole Board until she had served a minimum of four years in custody.

By May 2005, she had been in the prison system for almost eight years. At that time, she was in HMP Styal and she formally requested a 12 month deferral of her Parole Board hearing. She explained, in making her request, that having reviewed her past sentence planning reports she realised that she had work to do if she was to be able to prove herself ready for a move to 'open conditions'. The woman's request was granted and she was informed that the Parole Board would aim to hear her case in December 2006.

In August 2005, and still while she was in Styal, the woman took another prisoner hostage and barricaded herself into her cell. Shortly after this, she was transferred from Styal to Holloway.

On arriving in Holloway on 9 September, the woman was met in reception by a Principal Officer (PO). The PO had previously managed the life sentence prisoners' unit at HMP Bullwood Hall, and had worked closely with the woman when she was in that prison some years before. The PO said that the woman was a person who needed a lot of time and encouragement from staff. In those days, she was a person who would be affected badly by disagreements with other prisoners. She also tended to worry unduly about trivial matters and would be prone to irrational thinking. The woman was also inclined to self-harming behaviour by cutting herself. The PO established a good relationship with the woman and that was one of the reasons for making a point of meeting her when she arrived in Holloway following her transfer from Styal.

From reception at Holloway, the woman was initially located into the healthcare unit for close observation in view of her psychiatric problems. An ACCT form was opened immediately upon her arrival to ensure close monitoring in view of her tendency towards acts of self-harm – the woman was known to self-harm and had been monitored through the ACCT process while at Styal.

An entry in her medical record on 13 September referred to her having inflicted several superficial lacerations to her right arm during the early evening. Later that evening, she tied a ligature around her neck. Staff removed the ligature which was noted to have caused a slight red mark. The record went on to state that close observations were maintained and that the woman had settled and slept well.

On the evening of 14 September, the woman was noted to have used a pan scourer to give herself superficial abrasions to her left arm.

The woman remained in healthcare until the afternoon of 16 September when she was transferred to Holloway's life sentence prisoner unit (A5).

The woman saw one of the prison doctors on the late morning of 19 September. She had again used a pan scourer on her left arm and the doctor noted that the wound looked infected and was 'weeping'. Karen also told the doctor that her boyfriend had had a heart attack.

A Nurse told the investigators that she was responsible for the nursing care of the women in A5 and also for the women in B5. The Nurse told the investigators that she would see the woman on a daily basis for issue of medication. In addition, the woman was a person who enjoyed chatting, so each time the Nurse went to the unit the woman would engage her in conversation. Having these conversations with her helped the Nurse to assess her moods, which was needed for making entries in the ACCT form. The Nurse remembered a conversation with the woman on 20 September when she said that she had received a letter to say that a friend had died from a drugs overdose. The woman was upset, but her mood was stable and she had no suicidal thoughts.

At a consultation with a visiting psychiatrist from a nearby mental health Trust on 21 September, the woman spoke about the occasion when she had taken a hostage at Styal. She said that to have taken someone hostage was not normal behaviour for her. She added that she had had a difficult few months – a male friend had had a heart attack, a friend at Styal had committed suicide, she had heard that her grandmother was ill and August was the first anniversary of her grandfather's death. The woman told the psychiatrist that, with her grandfather already dead and her grandmother approaching the end of her life, she felt unable to think she had a future. She also said that it had been a 'spur of the moment' decision to take a hostage, and that she had been informed that she might receive an additional ten years to her sentence as a result.

On 25 September, a Nurse noted that the woman had used glass fragments to inflict superficial cuts to the whole of her right arm. At interview with the investigators, the Nurse said that the woman had received a letter to say that a friend had committed suicide. The Nurse said that she spent 20 to 25 minutes with the woman. The woman felt very low about what had happened to her friend and she had harmed herself as a way of expressing her inner feelings.

An officer working in A5, also told the investigators that the woman took up a lot of staff time. For instance, she seemed to bring to officers' attention fairly trivial matters that she could have dealt with herself. He added, though, that an aspect of the work in the lifer unit generally is that a lot of the women there can be demanding of staff time. On 26 September, the Officer made an entry in the woman's ACCT form about her coming to the wing office to report that she had used a piece of glass to make minor cuts to her stomach. The Officer said that it was a pattern of behaviour on the woman's part that she would carry out acts of minor self-harm, such as small cuts or cigarette burns, and

then report the incident to staff. The woman was always calm when reporting these incidents.

On the morning of 8 October, an entry in the woman's medical record referred to her having used a piece from a broken china mug to inflict multiple lacerations to her left arm. Steri-strips (wound closure strips) were used to treat the injuries. An Officer, another of the officers from the unit, made many entries in the woman's ACCT form on 8 October. These entries show that she had been low in mood for the whole of the day. In an entry made at 10.30am, the Officer recorded that the woman said she was experiencing bad memories from her childhood. She also said that she had been thinking of harming herself, but had since changed her mind and decided not to do so. A few hours later the woman changed her mind again and used a lighted cigarette to burn her hand. At interview, the Officer said that she spent some time chatting with the woman on 8 October. The woman had only wanted to talk about mundane things and although she mentioned her childhood, she did not want to go into detail.

On 17 October, the Officer noted on the woman's ACCT form that she had said that she had suicidal thoughts. At interview, the Officer said that he could not recall that particular day.

Another Officer made several entries in the woman's ACCT form on 19 October. The first entry was made at just after 1pm when the Officer noted that the woman had thanked him for sorting out her canteen. In an entry timed 9.19pm, the Officer noted that he had had a long chat with the woman who admitted that she had a razor in her possession and was refusing to hand it over. The note went on to report that the woman had said that she found self-harming to be a 'great' coping mechanism. At interview, the Officer said that the woman's moods tended to fluctuate quite markedly. He had had a number of conversations with her during her time at Holloway, but he did not think that she had ever been really open with him. She did say, though, that she was fed up with prison and she was also worried that perhaps eight or ten years might be added to her sentence following the hostage taking at Styal.

Later that same night, the woman told other staff that she had swallowed the razor blade. However, on being questioned further, she withdrew what she had said. Later on again that night, the woman used a broken spoon to inflict superficial scratches on both her upper arms.

On 20 October, the woman was moved to a different room in the lifer wing. The new room became vacant when the occupant was transferred to another prison and the woman asked to move into it, as it was next door to one of her friends. An Officer was involved in arranging the move and the woman thanked her for doing this for her.

A Nurse told the investigators that she spent a long time with the woman on the evening of 26 October. She had asked the Nurse if she could speak with her in private so the Nurse went into her room. The woman looked unwell that day – she was pale, she had wrapped herself in a blanket and she seemed shivery. The woman spoke

about her life in prison, about her family, about her boyfriend and about friends who had died in prison. The woman showed the Nurse some burn marks on her leg, but it seemed to the Nurse that these were old and not marks that had been inflicted recently. The woman told the Nurse that the doctor had promised to prescribe medication for a hormonal problem, but she was still waiting for that medication to start. The woman also said that she was not sleeping well, so the Nurse went to ask a prison doctor to prescribe an increased dose of sleeping pills to commence that night. When the Nurse returned to give the woman the extra medication, the woman thanked her and also thanked the Nurse for spending time and listening. The Nurse said that when she left the woman that evening she 'did not think for one minute' that she would take her life two days later.

On 27 October, the woman came back to the unit very upset following a doctor's appointment. An Officer wrote an entry in the woman's ACCT form recording her saying that she wanted to kill herself. The Officer was also on duty and said that the woman was upset about a number of things including that a prison doctor had refused to prescribe certain medication. The Officer said that he spent around half an hour talking to her in her room trying to calm her down. The Officer thought that the woman did calm down as they spoke and, by the time he left her room, it did not seem to him that there was a problem any longer.

THE DAY OF THE WOMAN'S DEATH: 28 OCTOBER

At about 10am on 28 October, the woman had an argument with an Officer after she was asked about what she would be doing that day. The argument ended with the woman swearing at the Officer and throwing objects at her. The Officer reported the incident to a Senior Officer (SO) and she said that she wanted to place the woman on disciplinary report. However, the SO advised the Officer to deal with the incident by giving the woman an Incentive and Earned Privileges (IEP) warning. The SO told the investigators that prisoners have to acquire three IEP warnings before they become liable to lose privileges. Later that day, the woman approached the SO and thanked her for dealing with the matter in this way.

At around 5.30pm that afternoon, an Officer made a note in the woman's records that she did not '*seem her high spirited self*'. At interview, the Officer said that he asked the woman how she was and she had replied '*fantastic*' in a sarcastic tone of voice. He said, however, that it was not unusual for her to be like that.

The Nurse was issuing evening medication at around 7pm when the woman told her that she had been given a job to work in the prison laundry. The woman said that she was due to start on the following Monday and she was very happy about that. The woman also mentioned that some of the prisoners were shouting about the smell from the incense she was burning in her room. The Nurse told her that she liked the smell and that she should not take any notice of what the other prisoners were shouting. The woman said that she was pleased that the Nurse liked the incense. The Nurse said that she and an Officer then left.

The Officer said that, at the time that the Nurse was giving the woman her evening medication, which was at around 7.10pm, one of the other prisoners complained loudly about the smell being made from the joss sticks that the woman was burning in her room. The Officer told the prisoner that he would try to resolve the problem and then went to speak to the woman. He asked the woman to make sure that her cell door and door hatch were closed whenever she wanted to burn joss sticks.

The Officer said that it was in the woman's nature to be asked to be left alone if she was upset, but after a few minutes she would calm down and then be willing to talk. At the time that the Officer was talking to the woman about her joss sticks, she was upset because she felt she was being picked on. The Officer asked the woman whether she wanted to talk about the situation. She said that she wanted to be left alone, so the Officer went to the office to attend to other work that needed to be done there.

THE DISCOVERY OF THE WOMAN'S DEATH

About 15 minutes after he had last seen her, the Officer went back to the woman's room to see how she was. When he looked into the cell, he saw that she was hanging. She had used a ligature which she had tied to the window frame. The Officer used his radio to call a Code Blue alert to summon urgent medical assistance (a Code Blue alert indicates a potentially life threatening situation). The Officer went into the woman's cell and supported her body. When two Senior Officers arrived they freed the woman from the ligature and laid her onto the floor. The Officer said that the Senior Officers commenced attempts to resuscitate the woman and he telephoned the communications room to ask for all nurses to attend and for an ambulance to be called.

One of the Senior Officers said that she heard a Code Blue call on the radio for A5 wing and ran to that unit. She reached the woman's cell at the same moment as the second SO and they saw the Officer supporting the woman's body. One of the Senior Officers stood on a chair and cut the ligature with her anti-ligature knife. They then laid the woman onto the floor and checked for presence of a pulse. One of the Senior Officers said that the woman had no pulse and so she and the other SO started attempts to resuscitate her. One SO gave chest compressions, while the other SO gave mouth to mouth breathing.

One of the Senior Officers said that it seemed to take a long time for nursing support to arrive and she radioed the communications room to say that a nurse was needed urgently. First a Nurse arrived, and later a Senior Nurse. One of the Senior Officers said that, even after the nurses had arrived, she and the other SO were left to continue in their efforts to try to resuscitate the woman – the nursing staff did not offer to relieve them from this task. One of the Senior Officers added that she had received resuscitation training eight years before but had had no update training since then, despite requesting such training.

The second SO's evidence at interview with the investigators was very similar to that given by the first SO. This SO also said that it had been some time since she had last had resuscitation training, and she was angry that nursing staff had not offered to relieve her and her fellow SO in their attempts to resuscitate Karen. Nor had they offered any words of encouragement or said anything to confirm that she and her colleague were using correct techniques in their efforts. The SO was also annoyed that, when she arrived in the woman's room, she had had to move some of the furniture in order to make space to try to help the woman. The SO said that, for health and safety reasons, Holloway has a 'room plan'. However, many of the women have additional furniture in their rooms.

The Nurse said that when the Code Blue alarm sounded, she was giving evening medication to the women on B5 unit (B5 is the unit adjoining the lifer unit). Before the Nurse could respond to the Code Blue, she first had to secure the medicine trolley by locking it into the nurses' office. At the same time, she

collected the 'blue bag' (a bag containing emergency medical equipment, including oxygen). The Nurse said that, when she reached the woman's room, she checked her for a pulse and signs of breathing, but found no such signs. The Nurse said she gave the woman oxygen while the two Senior Officers continued with their efforts to resuscitate her.

A Senior Nurse was designated as 'Hotel 1' that day (Hotel 1 is the call sign of the member of staff with primary responsibility for responding to serious clinical incidents). At the time that the Code Blue alert was issued for the woman, the Senior Nurse was in Holloway's mother and baby unit. She had been called urgently to the unit because one of the mothers was concerned that her baby had meningitis. The Senior Nurse made her way as quickly as possible to the lifer unit, but this took her around five or six minutes due to the distance between the two units and the number of security doors (perhaps eight to ten) that she had to unlock and then relock as she went.

The Senior Nurse said that when she arrived, the two Senior Officers were attempting to resuscitate the woman. The Senior Nurse was content for the Senior Officers to continue with what they were doing, while she used the defibrillator to check whether an electrical shock should be given. The Senior Nurse helped in giving the woman oxygen.

In a statement about her involvement, a PO wrote that when she arrived she could see that there was a problem with the attempts to try to ventilate the woman and so she took over with giving mouth-to-mouth breathing.

When the ambulance paramedics arrived they took over the attempts to try to resuscitate the woman and they then took her to hospital. Unfortunately all efforts to save her proved unsuccessful and she was pronounced dead at hospital at 8.29pm.

All of the staff interviewed as part of this investigation reported their surprise that the woman had taken her life. Although they all knew her to be a person who would carry out acts of self-harm, the cuts and burns she would inflict on herself at Holloway were always minor and never life threatening. However, the clinical review at page 29 cites evidence of a serious overdose that the woman had taken just two months earlier at Styal.

THE WOMAN'S LETTER TO HER AUNT

Following the woman's death, one of the other prisoners, a wing cleaner, gave an SO a letter that the woman had written to her aunt. The letter, which is seven pages long, is dated 28 October and it seems that the woman gave this letter to the cleaner that evening. It seems she started the letter at 12.00 noon and it opens in a light hearted style. The woman mentions her delight that she is due to start work in the prison laundry on the approaching Monday. However, the letter quickly changes in tone. By its end, the woman clearly indicates that she can see no future for herself and she informs her aunt that she has decided to take her own life.

AFTER THE WOMAN'S DEATH

The woman's mother, step-father and aunt all live in the West Midlands. On the evening of 28 October, the Governor of Holloway, telephoned the family to notify them of the woman's death. The Governor had previously been the Governor of HMP Bullwood Hall and he had had quite a lot of contact with the woman when she had been in that prison. It was because of this connection that the Governor wanted to contact the woman's family himself, in preference to arranging for a visit to be made by either the police or prison representatives local to the family homes.

On 29 October, Holloway's Family Liaison Officer, telephoned the family, offered her condolences and offered the family the opportunity to come to the prison and to visit the woman's room. The Family Liaison Officer also gave the family her contact details.

The Governor and Family Liaison Officer visited the family on 3 November when they returned the woman's property. The family was told that Holloway would pay the funeral costs.

The woman's funeral service was held in the West Midlands on 21 November. Holloway sent flowers and the Family Liaison Officer attended the service.

FINDINGS AND CONCLUSIONS

The woman was 30 years of age when she arrived at Holloway on 9 September 2005. She had been convicted of arson in 1997 when a discretionary life sentence was imposed. A four year tariff was set upon her conviction, but at the time of her transfer to Holloway she had already served eight years. Taking into account other sentences, the woman had been in prison custody for the greater part of the previous 11 years.

Shortly after arriving in Holloway, the woman was seen by a visiting consultant psychiatrist. During this consultation, the woman talked about the incident that occurred at HMP Styal when she had taken another prisoner hostage. She said that she had been going through a difficult period at that time. Among other things, it was the anniversary of the death of one grandparent and her other grandparent was ill. The woman also feared that she might receive a further ten years on her sentence for the hostage taking.

While at Styal, the woman had been subject to special monitoring through the ACCT process. Upon the woman's arrival at Holloway, the ACCT arrangement continued and she continued to be subject to special monitoring. Her tendency to commit acts of self-harm persisted. None of the woman's acts of self-harm resulted in serious injury.

There was great consistency in the evidence given to the investigators by the staff who had dealings with the woman. They described her as being demanding of their time, but it was obvious during their interviews that most of the staff liked her and were prepared to give her the attention that she so often seemed to need. It also emerged quite clearly that the woman's mood would fluctuate, and could fluctuate quite markedly within a brief period of time.

The woman received an IEP warning on 28 October following an incident when she threw objects at an officer who had questioned her about what she would be doing that day. The Officer wanted to deal with the incident by placing the woman on report but the SO advised the officer to issue an IEP warning instead. The woman was obviously pleased that the incident had been dealt with in that manner as she later thanked the SO for her intervention. An Officer made an entry in the woman's records in the late afternoon indicating that she had been rather low in mood that day. However, the Officer's evidence at interview, and the evidence of other staff, shows that it was not unusual for the woman to be low in mood.

The last time that the woman was seen alive was at about 7.10pm on 28 October. She spoke with both a Nurse and an Officer at this time. Although the woman was upset because of the comments some of the women were making about the smell of incense, it seems she was pleased to hear that the Nurse liked the smell. She was also pleased to tell the Nurse that she had a job to start on the following Monday.

There would not seem to have been anything about this encounter to have particularly differentiated it from many others.

The Officer had gone back to the wing office after speaking with the woman. About 15 minutes later he returned to her cell to see how she was and found her hanging from a ligature that she had tied to the window frame. The Officer raised the alarm and supported her body until two Senior Officers arrived. As soon as the woman was released from the ligature, staff checked her condition and commenced trying to resuscitate her. At interview, one of the Senior Officers mentioned her annoyance that the attempts to try to save the woman were hindered initially by the amount and layout of the furniture in the room. I draw this matter to the Governor's attention.

Two separate clinical reviews were carried out to assist in considering the woman's care and treatment at Holloway. One review, carried out by a consultant in emergency medicine, considered the response from staff when the woman was found hanging. The consultant's findings included that the response from prison officers was appropriate and timely. The delay in the arrival of Hotel 1, the Senior Nurse was understandable given that she was dealing with a sick child when the alarm was issued, and given that the mother and baby unit is some distance from the lifer wing. The consultant's overall conclusion was that when the woman was found and the code blue warning was issued, staff responded promptly and appropriately to their level of training and experience. However, the consultant has said that upon their arrival healthcare staff should have assisted in undertaking CPR (cardiopulmonary resuscitation).

The other clinical review conducted in this case was carried out by a consultant psychiatrist, who considered the woman's psychiatric care and treatment. The consultant psychiatrist has referred in his report to the woman's mood swings and her self-harming behaviour. He has also referred to the letter that she wrote to her aunt and he describes her mood as appearing to change from being reasonably cheerful to profoundly hopeless. The consultant psychiatrist's conclusion was that he did not believe that staff could have foreseen that the woman would take her life that day and his view was that all reasonable precautions were taken.

I concur with the findings of both clinical reviewers. The woman was clearly a very troubled woman who, by her own admission, engaged in self-harming behaviour as a coping mechanism. It seems she also took a serious overdose and left a suicide note at Styal two months before her death. However, all of the woman's acts of self-harm while at Holloway resulted in minor injuries only. Nothing occurred at any stage to alert Holloway staff that she might have any genuine thoughts about ending her life. Indeed, it is obvious from the tone of the woman's letter to her aunt that she was in high spirits when she began writing it. But as the consultant psychiatrist points out, her mood changed dramatically as she proceeded to reflect upon her life as the letter went on. In conclusion, I am satisfied that staff could not have anticipated that the woman was intending to take her life. I am also satisfied that the efforts made by

the two Senior Officers in attempting to resuscitate the woman were prompt and appropriate.

I further judge that the action taken by the Governor and Family Liaison Officer in the aftermath of the woman's death was sensitive and kind, reflecting well on themselves, their prison, and the Prison Service as a whole.

RECOMMENDATIONS

The following recommendations are drawn from the two clinical reviews obtained in the woman's case. The recommendations appear in full in the two separate reports, but I summarise them below: The Prison Service's responses following issue of the draft report and recommendations are set out below each recommendation:

OPERATIONAL RECOMMENDATIONS

1. Safe cells without ligature points should be available for prisoners who regularly self-harm or make suicide attempts.

Prison Service response: *HMP Holloway has 25 safer cells, predominately located in Healthcare. The woman was not considered to be at high risk so was not located in a safer cell.*

2. Consideration should be given to introducing a system to ensure that Hotel 1 is able to attend to emergency calls free of clinical duties that might lead to conflicting priorities.

Prison Service response: *Partially accepted. This is not practical however there is a nominated person who acts as Hotel 2 who, along with other nursing staff, can take over in this instance.*

A further training session will take place focusing on the action to take at the reporting of a code blue incident and further development of the code blue system via the radio.

3. Consideration should be given to introducing a highest category of 'Code Blue' response that is clearly reserved for true life threatening situations.

Prison Service response: *Accepted. Consideration will be given to the development of the response codes.*

HEALTH RECOMMENDATIONS

4. Electronic patient records with a common data spine should be made available as soon as possible across all prisons.

Prison Service response: *Accepted. An NHS collective has begun to develop an implementation plan for the introduction of electronic patient records. They should be ready to present a completed plan in 2007.*

5. The Prison Service should consider whether a clinical summary and risk assessment of prisoners' medical and psychiatric care should be sent when the prisoner is transferred from one prison to another.

Prison Service response: *Accepted. PSO 3050, continuity of care, which was published in February 2006, sets out guidance on what medical information should be passed on when a prisoner is transferred between establishments.*

6. Clinical healthcare staff should receive annual updating of resuscitation skills in line with the recommendations of the Resuscitation Council UK.

Prison Service response: *Accepted locally.*

6.1. All new members of staff should have resuscitation training as part of their induction programme.

Prison Service response: *Accepted. All new members of staff receive Heart Start training as part of their POELT training.*

6.2. Non-clinical staff trained in life support should be clearly identified as a means of providing additional support to the healthcare staff in the event of a cardiac arrest.

Prison Service response: *Accepted. Staff trained in first aid will be incorporated into the response protocol.*

6.3. Plans should be made for all operational staff to receive refresher training in resuscitation skills.

Prison Service response: *Accepted locally.*

6.4. Attendance on Immediate Life Support (ILS) courses should be considered for selected members of the non-clinical staff who wish to enhance their skills.

Prison Service response: *Accepted. All staff are considered for training when it is available.*

7. I recommend the placement of additional defibrillators around the prison and a system where the nearest defibrillator is automatically brought to the scene of a 'Code Blue' incident so if needed it can be brought into use without delay.

Prison Service response: *Partially accepted. Defibrillators are placed strategically around the prison. An additional one is being placed onto*

Level 4 and there will be better signs to inform staff where they are located.

8. Sufficient supplies of facemasks and gloves should be readily available to all prison staff who respond to emergency medical/cardiac arrest situations.

Prison Service response: *Accepted. All staff are issued with a pouch that can be carried on the belt. In addition there are grab boxes in all unit offices that contain a minimum of 3 pairs of gloves and 2 non-returnable valve face masks.*

9. I recommend that clinical debriefings be held shortly after significant clinical incidents to allow staff to discuss what occurred from a clinical point of view.

Prison Service response: *Accepted. A hot-debrief is held following all serious incidents. The clinical team will ensure that non-clinical staff are included in their debrief when they have been involved in any life threatening incident.*

10. On the assumption that the prison doctors have training in basic and possibly advanced life support, their role, if they are present in the prison at the time of an incident, should be more clearly defined.

Prison Service response: *Accepted. Further consideration will be given to the most senior member of healthcare to carry a radio and attend the scene of incidents.*