

**INVESTIGATION INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF A WOMAN AT HMP
EASTWOOD PARK IN JANUARY 2007**

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

May 2008

This report considers the circumstances surrounding the death of a woman in January 2007 at HMP Eastwood Park. The woman was found hanging in her room 40 minutes after the 2:00pm cell unlock. Despite attempts at resuscitation, staff and paramedics were unable to revive her. She was 26 years old.

I extend my personal condolences to the woman's family and to all those touched by her death.

One of my investigators undertook the investigation with the assistance of another colleague. I would like to thank the Governor of Eastwood Park and his staff for their cooperation during this investigation. I am also grateful to the Medical Practitioner from Bristol Primary Care Trust, who has carried out a clinical review of the care the woman received during her time in custody.

The woman had a history of substance misuse and occasional depressive periods. She had tried to take her life on several other occasions whilst outside of prison. On 3 January 2007, she was diagnosed as depressed and prescribed antidepressants. However, she did not present to discipline staff or the doctor as suicidal at this time.

It has not been possible to determine precisely why the woman chose to take her life, but her family remain convinced that her depression and her actions are heavily linked to the adoption of her children. It should be noted that there is no evidence to suggest that she has ever revealed the extent of her concerns about the adoption to any staff at Eastwood Park.

My report draws attention to one of the themes of the Corston report (*A review of women with particular vulnerabilities in the criminal justice system*) that services for women in the penal system need to be better co-ordinated and more woman-focussed. I make five recommendations relating to the woman's care. Three of these recommendations, plus significant textual amendments and additions, have been made after consultation on the first draft of this report.

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May 2008

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SUMMARY

The woman was taken into police custody on 29 November 2006. She stayed in a police cell overnight before being remanded into custody at HMP Eastwood Park. Whilst at the police station, she was considered a potential risk for self-harm due to her past record of suicide attempts. She was also withdrawing from drugs.

On arrival at Eastwood Park, the woman did not present as being a risk to herself. She seemed calm and relaxed. Due to her substance misuse, she was placed on the detoxification wing for a standard detoxification regime. If she had not been placed on the detoxification wing, she would have been recommended for a mental health assessment as she was recorded as having no fixed abode before coming into custody. This assessment should have taken place on completing her detox, but no appointment had been made.

The woman settled into the prison regime quickly and made friends with other women on her wing. It was well known amongst prisoners and staff that her children had been taken into care, but no one was aware how upset she was as a consequence. She did not appear depressed and gave staff no reason to be actively concerned about her mental wellbeing.

On 20 December, the woman told a CARAT worker that she would kill herself if sentenced to more than three years in prison. She did not appear upset when she made this statement. In fact, the CARAT worker stressed to my investigator that it was a flippant comment and she was not left with the impression that she meant what she said.

On 3 January 2007, the woman went to see a doctor as she was feeling low. The doctor diagnosed depression and prescribed an antidepressant. A follow-up appointment was scheduled for a fortnight's time. The doctor was very clear that she did not present as being suicidal.

The woman went to court on 4 January for sentencing. The hearing was adjourned and she was returned to Eastwood Park. She was reported as appearing well on return and no concerns were raised. The following afternoon, she was found by a fellow prisoner. She was hanging in her cell, 40 minutes after the 2:00pm unlock. Despite attempts to resuscitate her, paramedics pronounced her dead half an hour later.

THE INVESTIGATION PROCESS

1. The lead investigator opened the investigation on 8 January 2007. She discussed the circumstances surrounding the woman's death with the Eastwood Park's Governor.
2. The lead investigator visited the prison with a colleague on 12 January to receive a more in-depth briefing, chaired by the Governor. In addition to the briefing, my investigators were provided with all documentation relating to the woman's period in custody.
3. The lead investigator wrote to South Gloucestershire Primary Care Trust (PCT) requesting a clinical review of the healthcare the woman received in custody. A Medical Practitioner from Bristol PCT was nominated to conduct the review. The lead investigator and the clinical reviewer agreed to hold joint interviews with the main healthcare staff who had provided care for the woman at Eastwood Park. The lead investigator conducted all other interviews at the prison with her colleague. On concluding the interviews, both investigators provided verbal feedback to the Governor on their findings.
4. The woman's family was contacted by one of my Family Liaison Officers to explain the purpose of the investigation and to allow them the opportunity to raise any concerns. The woman's family accepted the offer of a visit. This took place on 27 February. The family asked my investigator to answer the following questions:
 - What had the woman been charged with?
 - Who was the social worker at the prison that the woman told her parents she had spoken to?
 - Did a social worker from Sandwell Council visit or send a letter to her the week before her death? Was there any other message sent to her via prison staff?
 - Why was she in a single cell? Was there any record of why and when she was moved from a shared cell?
 - What happened in court on the Wednesday (4 January) before her death?
 - Who is her female friend? (A woman had written to the woman's father via her ex-partner.) The family requested that this woman be contacted in case she had any information about the deceased's state of mind whilst she was in prison.
 - Is there any record of the prison checking the contents of the woman's letter to her ex-partner on 31 December 2006?
5. The first five issues are addressed in the main body of the report. In relation to the sixth point, the female friend was the woman's friend in prison. They were based in separate prison wings, but had become friends whilst they were on the detoxification wing. My investigator was unable to speak to her as she had been released from Eastwood Park.

The police managed to locate her through a forwarding address left at the prison. A telephone message was left at the address asking her to contact the police, but she chose not to. The matter was not pursued as she was not considered to be party to, or have pertinent information regarding the woman's death.

6. My investigator looked into the final issue. The woman wrote to her ex-partner on 31 December 2006, telling him that she had tried to harm herself. Her family asked why, considering the content of the letter, she had not been placed on a suicide watch. They wanted to know if prison staff were aware of the letter and, if they were, why no action had been taken. However, not all letters sent by prisoners at Eastwood Park are read before they are posted. Approximately one in every fifteen letters is randomly selected for screening. Some letters are routinely monitored, for example if the sender has been prohibited from contacting specific people as a result of their offence. However, it is right that prisoners generally should be able to correspond without their letters routinely being read by prison staff. It is therefore entirely reasonable that prison staff were not aware of the content of the woman's letter.

HMP EASTWOOD PARK

7. Eastwood Park is a closed women's prison in South Gloucestershire serving the West of England, South Wales, South of England and the Midlands area (including Birmingham). It was previously a male Young Offenders Institution, and opened for women after refurbishment on 1 March 1996.
8. The prison's operational capacity is 362 women. There are three residential blocks. Residential I has three wings: A (first night centre), B (detoxification wing) and C (unconvicted adults). Residential II accommodates a maximum of 156 women comprising 98 sentenced and remanded adults on E wing, and 58 young offenders and juvenile prisoners on D wing. Residential III houses 40 sentenced prisoners. G wing accommodates 18 women in a semi-open dormitory. There is also a mother and baby unit (up to 12 women) and a designated juvenile unit (housing approximately 16 young women).
9. Eastwood Park has 24-hour healthcare provision. There are 12 inpatient beds in the centre (although the inpatient facility was closed at the time of the woman's death). The General Practitioner (GP) provision is supplied by a GP practice. There are also other visiting practitioners who provide a wide range of clinics – for example, dentist, family planning, well woman's clinic.
10. The regime at Eastwood Park is diverse and includes domestic cleaning work, purposeful activity on the wings and a wide variety of employment. The education department offers Basic Skills entry level, National Open College Network certificates in money management, alcohol, drug and anger awareness, cookery, parentcraft, citizenship, preparation for employment, visual arts and textiles along with other courses. A number of voluntary organisations attend the establishment to do group work with the women.
11. Eastwood Park receives a large number of prisoners with a history of drug abuse, mental illness or serious harm – or all three. Since the report in 2003 by HM Chief Inspector of Prisons, the establishment has strengthened its procedures for managing early days in custody and for dealing with anti-bullying, suicide and self-harm. However, the sheer volume of those on suicide and self-harm support and monitoring arrangements places a great strain on the mechanisms for effective monitoring and intervention. The Inspectorate has commended the generally respectful and caring environment in which staff do their best for some extremely damaged women and girls.
12. Relations between staff and prisoners are generally good. As in other women's prisons, there is a high incidence of self-harm which, in the view of the Independent Monitoring Board, staff at Eastwood Park deal with sensitively.

KEY FINDINGS

13. On 29 November 2006, the woman was taken into police custody charged with breaching her community order by committing a burglary. Whilst in custody, a police medical officer noted that she was withdrawing from crack cocaine and heroin. The woman admitted to having a history of substance misuse, depression and self-harm. She had also tried to commit suicide on several occasions, including a recent attempt. The woman told the medical officer that she last taken antidepressants 18 months before. The medical officer decided that she was a potential suicide risk and gave instructions for her to remain on CCTV camera observations whilst in the police cells. The following day, she was remanded into custody at HMP Eastwood Park until she was due to appear in court on 4 January 2007 to be sentenced.
14. On transfer to prison, her warrant, police custody record (notes of medical examination at the police station) and prison escort record (PER) were made available to staff on reception. The police custody record noted that the woman had received methadone whilst at the police station and that she had a history of self-harm, taking antidepressants and suicide attempts. The PER noted the history of substance abuse and self-harm, but there was no accompanying suicide and self-harm warning paperwork. The National Probation Service sent a fax at 4:40pm regarding her, marked for the attention of reception. This said, "probation has def[initely] recorded as self-harmer." Unfortunately, this was not sent to a fax machine based in the reception area. Due to the time it was sent, the fax was not noticed until the following day. It is not clear to whom the document was passed and if anyone took notice of it. My investigator found the fax within the woman's prison records, but during her enquiries was unable to identify a member of staff who remembered seeing the document.
15. The wing Senior Officer (SO) was the first member of staff to speak with the woman in reception. She conducted an interview with her to complete a Cell Sharing Risk Assessment. This assessed whether the woman had any medical or mental health problems, or was a risk to herself or to others. As with all prisoners, the interview was based on information the prisoner chose to give and the paperwork provided by the escort staff. Through talking to the woman, the wing SO did not note any reason to be actively concerned about any risk of self-harm or suicide. She wrote that the woman appeared "calm and relaxed".
16. The woman was then seen by the Healthcare Assistant (HCA). The initial healthcare screen is an eight page assessment that asks questions relating to physical and mental health, as well as substance misuse. During an interview with my investigator, the HCA said that he clearly remembered her. He said that she appeared to be suffering symptoms of withdrawal from drugs and, although she said that she had previously tried to take her life, she did not have the desire to commit suicide or self-harm at this time. She did not tell him that she had

previously taken antidepressants. On recording his impression of her behaviour and mental state the HCA wrote, “good conversation, positive attitude to why she wanted to come into prison”. He concluded that she was not at immediate risk, but that she should be monitored. The HCA found no reason to open an ACCT (Assessment, Care in Custody and Teamwork) document. (This document is used by staff to manage the care of a prisoner considered to be at risk of harming themselves.)

17. Due to her history of substance misuse, the woman was appropriately referred to the GP and placed on a three week detoxification programme. The woman said that she would submit a self-referral form to the CARAT team (Counselling, Assessment, Referral, Advice, Throughcare) to address her substance misuse in the long term. As she declared herself as having no fixed abode on coming into custody, she should have also been routinely referred to the Mental Health Team for assessment. However, the policy at Eastwood Park is that women undergoing a detoxification regime will not meet the Mental Health Team until the programme is complete. The reason is that the Mental Health Team would not be able to accurately assess a person’s mental health whilst they were withdrawing from drugs and/or alcohol. The appointment should be automatically generated when the detoxification is complete. In the woman’s case this did not happen and she had no contact with the mental health team.
18. The woman was allocated a cell on B wing, the substance misuse unit. She was seen by a GP at the prison, who prescribed diazepam 60mg and methadone 20mg. The methadone would be increased by 5mg over the next two days. This dose would then be gradually reduced by 5mg each day over the next 15 days until the woman completed her detoxification. The diazepam would be phased out over the course of a month.
19. A second health screen to glean further medical information about the woman took place on 7 December with the staff nurse. This was a more thorough health screen to determine if she needed to be referred to any specific clinics or support networks. During this interview, the woman discussed her substance misuse history but did not mention any mental health problems or concerns about feeling depressed.
20. There are regular entries in her medical record that indicate she was seen by healthcare staff during her detoxification. No medical problems are reported, either physical or mental, until 11 December when the staff nurse brought her to the healthcare centre after an incident with another prisoner who had thrown hot water at the woman. Some had gone in her left eye and on her left hand, but she was not severely injured. Both her eye and hand were bathed in cold water by the staff nurse and a cream applied. My investigator tried to find a security incident report relating to this event, but the prison had no record of one. The staff nurse told my investigator that she could not remember anything further about the event, only that the woman had said it was an accident.

21. The woman was next seen by a nurse on 12 December. She complained of being unable to sleep and was prescribed zopiclone (sleeping tablets) to be started the following night. On 15 December, the woman was discharged to the police station for questioning. She admitted to four further burglaries and was returned to Eastwood Park.
22. Other than reporting difficulty sleeping, the woman was noted to be coping well until 16 December when the second HCA recorded, "observed upset during showing pictures of her children to fellow prisoners, has otherwise remained settled and not stated any medical problems". When questioned about this entry, the second HCA said that there was nothing more significant about his observation. The woman had been in a corridor holding photographs of her children and she went up to the HCA and said, "these are my children". She appeared tearful. The woman moved on to show other prisoners the photographs. The HCA said that to observe a prisoner being tearful over their children was a regular occurrence, and the woman's tears did not alarm him.
23. On 18 December, the woman completed her detoxification and moved from the substance misuse unit to E wing. This is a busy wing occupied by women on remand or with short sentences. She was placed in a single occupancy cell with a bunk bed.
24. Two days later, a CARAT worker, had an introductory meeting with the woman to complete a drug interventions record. This had been arranged after the woman's self-referral submitted on 4 December. The purpose of completing the interventions record is to determine what kind of support the prisoner needs and to set objectives for both their time in prison and in preparation for release. The woman spoke about her substance misuse and children. She told the CARAT worker that her reason for self-referral was that her children were being put up for adoption the following week. They also discussed her offence and possible sentence. The woman told the CARAT worker that she was facing a three to five year sentence and said, "if sentenced to over three years I will probably kill myself". My investigator questioned the CARAT worker at length about the woman's statement. She asked the CARAT worker how the woman had said this and if it had raised any alarm bells. The CARAT worker assured my investigator that the woman's comment had been said in a throwaway fashion and had genuinely not raised any concerns. It was simply a flippant statement.
25. On discussing a care plan to manage any arising needs, the woman said that she did not feel that she required any immediate support but would want a one to one meeting with the CARAT worker when she had been sentenced. The CARAT worker made a note of this and of the court date – 4 January 2007. A copy of the assessment was sent to Birmingham Drug Intervention Programme on 22 December so that they would have knowledge of the woman on her release.

26. Shortly before Christmas, the woman saw a prison social worker (SW) on E wing. The SW had been holding pilot wing surgeries with the resettlement team. The date of the woman's surgery with the SW is not logged in her prison records. The woman asked the SW to contact her parents regarding the residential order for two of her children. In asking her to do this the woman did not mention the adoption hearing, nor did she indicate the message was urgent. The SW did try to contact her parents, but there was no answer when she called. She did not try again so the woman's message was not passed on.
27. The woman was caught fighting with a fellow prisoner on Christmas Eve. They were separated by staff and returned to their cells. Both were placed on disciplinary report, pending adjudication, on 27 December. Apparently there had been an ongoing dispute between them and staff had spoken to the woman about it earlier in the day. During the adjudication, the other prisoner said that she was not guilty of fighting. The woman said that they had resolved their differences. It was decided that further investigation was required before settling the issue and the adjudication was adjourned. There were no further incidents of disagreement between the two women.
28. On 3 January 2007, the woman made an appointment to see one of the GPs. The GP told my investigator that he recalled the consultation and that the woman appeared depressed. The woman told him that she had a "low mood" and "described how she was tearful ... and her appetite as being poor and she had poor concentration, she wasn't sleeping". The woman spoke about her children and how she was fearful of the last two being removed from her by Social Services. She did not make any reference to her children beyond this. The GP diagnosed her as clinically depressed and prescribed an antidepressant (citalopram). The woman said nothing about feeling suicidal and the GP had no fear that she might be. As she presented no risk to herself, the GP did not feel it was necessary to open an ACCT form (to monitor risk of self-harm and provide appropriate support). On prescribing her citalopram, the GP made plans for a follow-up appointment in two weeks. This was the last time he saw her.
29. The following day, the woman was taken to court for her adjourned sentencing. During the day at court she had a legal visit with her criminal solicitor and one with a representative from Addaction, a drug and alcohol counselling charity. The court hearing was adjourned again and rescheduled for 11 January. The woman was taken back to Eastwood Park. My investigator spoke to one of the officers on escort duty that day. The officer said that the woman appeared to be fine during the return journey and raised no concerns.
30. The adjudication regarding the woman's fight on Christmas Eve was reconvened. The other prisoner's account remained the same. She said that she was not guilty and that the woman had been the aggressor. The charges against the other prisoner were dismissed, as there was not

enough evidence to suggest that she fought back. Due to lack of evidence the matter was not taken any further. Later that day the woman requested a sleeping tablet and some Kalms (a natural stress reliever).

31. At midday on 5 January, the woman was seen at lunch with the other women on E wing. The wing officer recalled having a brief conversation with the woman. She told the wing officer that she missed her children, but during this conversation appeared her normal 'happy go lucky' self. In contrast, a fellow prisoner, prisoner A, recalled the woman appearing withdrawn and unresponsive during a conversation in the same period. Prisoner A had wanted to introduce the woman to another prisoner. However, the woman was not very responsive and prisoner A said that she could not understand what was wrong with her. At lunch, the woman also had contact with another prisoner, prisoner B. The woman told her that she loved her, gave her a hug and said that she would see her after dinner. Prisoner B said this was something that the woman did every day. The woman then took her lunch back to her cell. At 12:30pm, the women were locked behind their doors until 2:00pm when they are let out for the afternoon association period.
32. At 2:00pm, the first and the second prison officers unlocked the cells on E Wing. The second prison officer unlocked the right-hand side of the wing whilst the first prison officer unlocked the left. The woman's cell was on the left-hand side on the ground floor, cell 14. Unlock at this time of day is not a roll check. This means that there is no specific requirement for officers to get a verbal or visual response from each prisoner. Before unlocking a cell door, officers have to look through the observation panel to make sure that it is safe to unlock. The first prison officer explained to my investigator that he looked through the observation panel into the woman's cell and could not see her. He assumed that she was behind the privacy screen (which hides the toilet area), unlocked her door and moved along to the next cell. He did not offer any verbal contact with her. The first prison officer said that he had intended to pass by the woman's cell to get a response after unlocking the other doors, but did not as he was distracted by a conversation with another prisoner.
33. Approximately 40 minutes later (2:45pm) prisoner A passed the woman's door on her way to borrow a radio from another prisoner. In passing, she looked through the observation panel as the cell door was still closed. She told my investigator that it looked "like she was just standing there" facing the window. Prisoner A thought it strange that the woman did not turn round when she knocked on the door. Prisoner A carried on knocking and then opened the door. It was then that she realised that the woman was hanging from the wardrobe. She shouted, "Officer, she's hanging," and stayed by the door keeping other prisoners from entering the cell.

34. The second prison officer arrived at the woman's cell first. He ran straight in and saw the woman hanging from the right-hand side of the wardrobe. She had used a green bed sheet to make a ligature. The bed sheet had been hung over the top hinge of the wardrobe door. A chair that she had been standing on had been kicked to one side. The second prison officer lifted the woman, using one arm to support her weight and the other to cut the bed sheet with his anti-ligature knife (commonly known as a 'fish knife'). As the second prison officer tried to cut the ligature, the wing officer and the first prison officer entered the cell. Both helped the second prison officer lift the woman whilst he concentrated on cutting through the sheet. A third prison officer, who was also on E wing, ran to the cell thinking that a fight was occurring. She pressed her personal alarm for more officers to attend. On arriving at the cell she saw that it was a medical emergency and radioed for healthcare to assist. The third prison officer then concentrated on trying to move prisoners out of the way of the woman's cell.
35. Meanwhile, the ligature was cut down and the woman was placed on the floor. The bed sheet was untied from her neck. The woman's lips had turned blue and her skin was pale. Using his hand on her chest, the second prison officer tried to see if she was breathing. In the meantime, a fourth prison officer had entered the cell. She used her radio to again call for healthcare assistance and to raise a code blue alarm. (Code blue means that it is an emergency situation and the person has stopped breathing. This lets healthcare staff know what equipment to bring to the incident.) On hearing the code blue alert, two nurses left the healthcare unit, taking with them a defibrillator. There was no need to carry an emergency response bag over to the wing, as one is kept in the central office on the residential block situated between D and E wing. The first nurse headed straight to the cell, whilst the second went to pick up the emergency response bag. The distance between healthcare, D and E wing is short and the journey takes approximately three minutes.
36. The fourth prison officer helped the second prison officer start cardio pulmonary resuscitation (CPR) by trying to insert a resuscitation aid into the woman's mouth. Both officers are first aid trained. The woman's tongue was stiff, making it difficult to insert an airway. At this stage, the first nurse entered the cell and took over from the fourth prison officer. She inserted the resuscitation aid and gave a rescue breath. The wing officer swapped places with the second prison officer and began chest compressions. The second prison officer checked for a pulse whilst the wing officer and the first wing nurse continued with CPR. The second nurse arrived with the emergency bag. The nurses continued CPR using an ambu-bag and oxygen cylinder. The defibrillator was attached to the woman. A reading showed no signs of life, but they continued CPR, with officers taking turns to carry out chest compressions so as not to tire, until a doctor arrived.
37. A principal officer (PO) arrived at the cell three to four minutes after the alarm had been raised. At this time, the duty governor was also at the

cell. The PO radioed the control room to ask for an ambulance to be called. The incident log shows that an ambulance had also been requested at 2:47pm. The PO told my investigator that she was confident that staff had already made a request, but she wanted to make absolutely sure by radioing the control room herself.

38. One of the GPs on duty at the prison that day was a doctor that works solely in the Juvenile Unit, which is separate to the rest of the prison. At 2:50pm, she was alerted to the emergency situation on E wing by a second PO who asked if she would go with him to the wing as there was a 'code blue' situation. She agreed, picked up her stethoscope and followed him to the wing. They arrived at approximately 2:55pm and were directed to the woman's cell. The prison doctor was told that CPR had been going on for around ten minutes and that the paramedics were on their way. CPR continued but there was no cardiac output and the woman's pupils remained fixed and dilated. Her body was cold, unresponsive and pallid. At 3:05pm, the prison doctor took over the ambu-bag.
39. The paramedics arrived at 3:09pm. At this stage, staff had been attempting to revive the woman for 25 minutes without success. The paramedics swapped the defibrillator with one they had brought with them to check for signs of life. There were none and the woman was pronounced dead at 3:15pm. She was covered with a blanket and her cell was vacated.

Events after the woman's death

40. The staff involved in resuscitating the woman left the wing and went to the staff area on the residential block. The death in custody contingency plan was put into action and the Prison Service's Area Manager and National Operations Unit, and the Police and Coroner were informed.
41. Two Listeners (prisoners trained by the Samaritans) were brought over from F wing, along with the chaplaincy team, to help tell the women on D wing what had happened. D wing was told first because there had been a lot of shouting between the wings and the women were aware that a serious incident had taken place. The women were brought out to the middle of the landing to be told. Staff then moved to E wing to inform the women there of the woman's death. As the police and Coroner's Officer had not yet been to the prison, the women could not come out onto the landing. The first PO decided that the best way of informing the women was to do this cell by cell. She broke the news and another officer followed, letting them know that the chaplaincy team and Listeners were on the wing if they needed to speak with them. Unfortunately, some of the women found this insensitive and would have preferred to be told collectively so that they could support each other. While I sympathise with this view, given the size of the wing and the need to keep the area free for investigation purposes, staff managed the situation in the best

way they could. The other prisoners were allowed out of their cells to be together as soon as it was possible.

42. At 8.00pm, an officer made an entry in the E wing observation log referring to a conversation she had with prisoner B. The prisoner told the officer that another prisoner, prisoner C knew of a rumour that the woman intended to kill herself. Prisoner B said that despite knowing this, prisoner C did not tell anyone. The officer told my investigator that she did not recall speaking to prisoner C about the rumour. Had a conversation taken place, the officer said that she would have recorded it in the wing observation book. An entry by the duty SO the following morning, indicates that the incident had been noted and there were “no further repercussions [that] morning, however please continue to monitor”.
43. The three women who knew the woman and had found her that afternoon all had ACCT forms opened and were subject to close observation. This was good practice, but it would have been sensitive if staff had moved the women to different cells. All three women told my investigator that they found it difficult remaining on the wing or in their cells and would have benefited from being moved that day. They were eventually moved a few days later at their request.
44. The woman’s next of kin details were found and the deputy governor and the prison family liaison officer went to the family home to tell her parents at 8:35pm. The woman’s partner, also in custody at the time, was informed by the Governor at HMP Brockhill.
45. A hot debrief was held by the duty governor with all the staff involved. The first wing nurse reported that she felt the staff rotation during CPR had worked well and she felt strongly supported in their attempt to resuscitate the woman. After the debrief, the duty governor ensured that any staff who wanted to go home were relieved of their duties. Taxis were provided for those who did leave. He also arranged for the Samaritans to come to the prison the following day to see the Listeners and go to E wing to provide additional support.
46. The duty governor wrote letters of condolence to the woman’s parents and her partner, enclosing literature on bereavement and offering to help with the cost and arrangements for the funeral.
47. A memorial service was held at the prison.

ISSUES

Clinical review

48. The clinical review was undertaken by a clinical governance lead from Bristol Primary Care Trust. I have summarised the clinical review findings below.

Findings

49. The clinical reviewer was content with the level of screening regarding the woman's mental health during the reception health screen. He notes that the screening was carried out by an experienced member of staff who spent sufficient time with the woman. The issues regarding her previous suicide attempts were fully explored but there were no concerns at that time. She was then appropriately referred to, and seen by, a doctor to address her drug misuse and begin the detoxification programme.
50. The detoxification programme was managed routinely, with no evidence of significant issues. Documents confirm completion of both the methadone and diazepam portions of the detoxification programme.
51. On 3 January 2007, the woman was seen by one of the prison's GPs. He prescribed antidepressants and sleeping tablets. The GP's assessment concluded that it was appropriate to start both medications due to evidence of depression. He was very clear that the woman did not appear suicidal. The GP said that he had thought long and hard about this consultation after hearing about her death and still remained firm in his opinion that, when he saw her, she did not appear to be at significant risk of harming herself. He did not consider it appropriate to involve other clinicians in her care or open an ACCT, but a plan was made to review her after two weeks to assess her response to the medication.
52. Citalopram is an appropriate medication to give in this circumstance. Large scale studies have found that there is no clear evidence of an increased risk of self-harm and suicidal thoughts in young adults of 18 years or over using citalopram.
53. Regarding the resuscitation attempt carried out by the prison discipline and healthcare staff, there was clear evidence of an effective team approach between the nursing staff and the discipline staff. Leadership for resuscitation was provided from the nursing staff and then medical staff until the paramedics arrived. The paramedics arrived in a timely manner through prison security to the wing. Equipment was collected on the way by nursing staff. The resuscitation was undertaken effectively and in an organised and timely manner. (During meetings with the head of healthcare, my investigator and the clinical reviewer ascertained that resuscitation training is available and accessible to all staff.)

54. The clinical reviewer asked whether resuscitation could have been stopped at an earlier point. Evidence from several individuals indicates that from their first assessment of the woman it was unlikely that there would be a positive outcome to the resuscitation attempt. However, resuscitation was appropriately continued until the paramedic team arrived as they would be more experienced in advising when resuscitation should be stopped.

Recommendations

55. The clinical reviewer makes none.

Evidence of good practice

56. The clinical reviewer judges that the resuscitation was carried out calmly and effectively by the combined team of nurses and healthcare officers and later with the paramedics.
57. Learning from the resuscitation has been rolled out to other units within HMP Eastwood Park

Conclusion

58. The clinical reviewer reports that the woman died on 5 January 2007 of hanging. There were no significant issues found during her care by the Healthcare Team of HMP Eastwood Park that would have prevented the hanging or affected her resuscitation.

Further clinical issues

59. Following on from the clinical review, there are a couple of issues that I would like to raise on my own part.

Generating appointments

60. In exploring why a mental health assessment was not arranged for the woman after she had completed her detoxification programme, my investigator was unable to establish how this had been overlooked. Prior to the introduction of the computerised medical information system, staff manually generated appointments. During interviews with various members of the healthcare team (including mental health), my investigator tried to ascertain who would have been responsible for generating the appointment and where the need for an appointment would be noted. No one was able to identify which part of the healthcare department would do this. In addition, the need for an appointment was not noted in the woman's medical record. With the introduction of the computerised system the likelihood of a repeated oversight should be reduced. However, the head of healthcare should make sure that staff

responsible for making mental health appointments are clear about their responsibility.

The Head of Healthcare should ensure that staff responsible for generating mental health assessment appointments after a detoxification programme are clear of their responsibility.

Resuscitation equipment and preparation

61. During her interview, the prison doctor explained that she worked exclusively within the Juvenile Unit which is removed from the main prison and not serviced by Pathways (the main prison healthcare team). Therefore, she was not familiar with the protocol for attending a medical emergency in the main prison. The term 'code blue' was new to her, although she made an educated guess as to what it meant. Despite her limited experience in attending to 'code blue' emergencies in a prison setting, the doctor explained that she is fully trained and confident in CPR.
62. Attending the medical emergency made the prison doctor reflect on the measures in place in the Juvenile Unit for responding to similar situations. As a result, she was working on a firmer protocol for resuscitation procedures. For example, making the staff on the Unit aware of their role in an emergency, what equipment is available to them, preparing pre-packed strategically placed emergency response bags. The prison doctor also told my investigator that she was arranging for an outside agency to come and provide CPR training for all staff in the Juvenile Unit. It had unnerved her that the Juvenile Unit is based some distance from the main prison, and she wanted to make sure the staff on the Unit are as prepared as the Pathways staff. I think that this is both sensible and I commend the doctor's actions.

Policy

Cell unlock

63. The Prison Officer Entry Level Training covers procedures for unlocking a cell door. All officers are taught this as part of their basic training. Unlocking to conduct the initial morning and subsequent roll checks is slightly different to unlocking for association or work. The guidance in the first instance requires that an officer, "physically check the presence of the occupants in every cell. [The officer] must ensure that [he/she] receives a positive response from them by knocking on the door and awaiting a gesture of acknowledgement." In the event of no response, guidance indicates that the officer may need to open the cell to check that the prisoner has not escaped, or is not ill or dead.
64. It became apparent during this investigation that the procedure for unlocking cells at times other than for a roll check is not so stringent. Some officers do employ the same degree of thoroughness, whilst

others do not necessarily wait for a verbal response or physically see a prisoner before moving on to unlock the next cell. A cursory look through the observation hatch and unlocking the cell without opening door is not uncommon.

65. There is no local policy at Eastwood Park (or at other prisons) outlining the procedure for unlocking a cell, beyond the initial basic training given to each prison officer at the start of his or her career. This allows for the process to be open to interpretation and in some instances for the development of bad habits. A reason given to my investigator for not being so rigorous in checking prisoners outside of roll checks is the need to meet key performance indicators (for example, time targets for accomplishing tasks). However, unlocking cells is not a target driven activity. It is, therefore, an unsatisfactory reason for not being thorough at all times.
66. The officer who unlocked the woman's cell on the afternoon of 5 January said that he did not see her when he looked through the observation hatch. Forty minutes later, a prisoner found her suspended by a ligature from her wardrobe. For the sake of ensuring prisoner wellbeing, I would like to see officers employing fuller checks (getting a verbal response when prisoners are not seen) at all unlocks. This level of contact is part and parcel of the duty of care and may be enough to ensure that prisoners are well, and in some instances prevent or interrupt any risk of harm. This is particularly pertinent when officers are dealing with a particularly vulnerable population (in general, women in prison suffer much higher rates of self-harm than men). Whilst there is no certainty that speaking to the woman at 2:00pm would have changed the outcome, it would at least be possible to say whether she was alive and well at this time.

The Governor should remind officers that during all checks on prisoners they should receive either a visual or verbal response.

Contact with the woman regarding the adoption

67. My lead investigator tried at length to find out who told the woman that the adoption hearing would take place in January. The investigator spoke to Social Services and both solicitors working for the woman. None of them had discussed the issue of the adoption hearing during this time. A social worker at Sandwell Social Services had written to the woman's parents on 19 December 2006, seeking her whereabouts to give information about the adoption. The social worker told my investigator that she never spoke or wrote to the woman directly after this date. Neither was she aware of anyone from Sandwell Social Services directly contacting the woman.
68. The woman had two solicitors, both of whom confirmed that they did not give her any information during December or January about the adoption of her children. The solicitor who had been dealing with matters relating

to her offence, saw her on Wednesday 4 January. My investigator asked him whether he could disclose the nature of their conversation. He said that he was bound by client confidentiality but was able to clarify that he did not give her any professional legal advice regarding her children. That said, he told my investigator that they did have a conversation about her children and that she had told him about an adoption hearing to take place during that month (January). He stressed that the woman gave him this information and not the other way round.

69. My investigator asked the solicitor how the woman appeared during their meeting. He said that she was clearly concerned about her children, but that she was not visibly upset. From her appearance, he had no concern that she was a 'suicide risk' or anything approaching that. He was very surprised to hear the news that she had taken her life.
70. As part of the death in custody protocol, the prison contacted the woman's probation team in West Bromwich. The Avon and Somerset Probation Area record of contact, completed by notes that an officer spoke to the prison. The officer reiterated that the woman had been known to the team as being at risk of self-harm or suicide and that this had been communicated in a fax to the prison reception on 30 November 2006. This flagged the woman as being at risk of self-harm. It is not clear, however, that the probation team were aware of the proposed final visit that the woman was to have with her children before the adoption.

Conclusion

71. It seems that there was a distinct lack of communication between Social Services and Eastwood Park, West Bromwich Probation, and the woman's solicitors regarding the events building up to the adoption. The woman was going through an emotionally difficult period, yet few people were aware of the enormity or imminence of the situation. To further complicate matters, information that did filter through (the fax from the probation team and the woman's pre sentence report) was not picked up by staff at Eastwood Park, largely because the woman did not stand out as appearing troubled or depressed. Had she presented as depressed prior to 3 January, or indeed as a suicide risk, there would have been greater call for officers or healthcare staff to delve into any background information. As she did not, it would be unfair to apportion responsibility to any one party. Indeed, when the woman came into prison she said that she was happy to be in custody as it meant that she could get her life back on track.
72. It is difficult to expect a level of care and support to be put into place if the individual's need is not apparent. However, what can be expected is for the relevant agencies (Social Services, Probation, Prison) to work together more closely in addressing the needs of women prisoners. . By working together more closely it might be easier to identify and highlight when a prisoner is in crisis. Women prisoners are a particularly

vulnerable group. Great emotional strain is placed upon them due to separation from family, especially children. In some cases temporary separation leads to losing custody. Providing prison staff with information about imminent and difficult custody cases would allow for support mechanisms to be put in place to meet individual needs and prevent possible self-harm.

73. The Corston report (*A review of women with particular vulnerabilities in the criminal justice system*), published by the Home Office in early 2007, concludes that services for women in the penal system need to be better co-ordinated and more woman-focussed. This would not only contribute to a reduction of re-offending but would provide, “a seamless continuation of care and provision both inside and outside the prison walls”. The sad circumstances surrounding the death of this woman illustrate the importance of what the Corston report says.
74. It remains unclear why the woman decided to take her life. She had not confided in staff, prisoners or her family about the extent of her feelings. However, there was clearly a missed opportunity for her to receive a mental health assessment.
75. The staff response when the woman was discovered on 5 January was appropriate. Staff did the best that they could to try and revive her, persisting until the paramedics arrived and confirmed that she was beyond resuscitation. Even if she had been the subject of a mental health assessment, or if she had been seen or spoken to at 2:00pm when unlocked, there is no strong evidence to suggest that this would have altered the outcome.

RESPONSE TO COMMENTS ON THE DRAFT REPORT

82. In response to my issuing the draft of this report the Prison Service requested clarification of a number of matters.
83. The Prison Service asked how much information was sent from the police about the woman's previous self-harm and suicide attempts. The police medical examination form travelled with the woman's warrant and prison escort record to Eastwood Park and would have been available during the reception process. The form states that the woman had a history of self-harm and suicide attempts. There were no separate self-harm or suicide awareness documents.
84. Further clarification was sought on whether the woman spent any time in the care and separation unit (segregation) after the incident with another prisoner on 24 December. As I say in paragraph 34, both women returned to their cells. The woman was not segregated.
85. South Gloucestershire Primary Care Trust has discussed the draft report with the Strategic Health Authority and the newly established local Prison Governance Committee. The PCT will share the final report with the PCT's Integrated Governance Committee to ensure that any actions for clinical or mental healthcare are implemented.
86. The PCT state that since the woman's death several changes have been made to the mental health referral process and efforts are being made to improve access to mental health services within the prison. The time taken for prisoners with a known mental health diagnosis to have been seen by the mental health team will be audited. The need for improving CPR training and associated procedures in the Mary Carpenter Wing (the juvenile wing of the prison) has been acknowledged.
87. The woman's family have asked for clarification of the following areas:
- The prison's knowledge of the woman's vulnerability
 - The post mortem report
 - The passing on of information and records
 - The process of ascertaining whether prisoners are a suicide risk
 - Interview with the Prison GP
 - Personal Officer scheme
 - Interview with the Prison Head of Healthcare
 - Lesson learning from previous deaths in custody
 - HM Chief Inspector of Prisons' Report, March 2006

I address these matters in turn.

The prison's knowledge of the woman's vulnerability

88. The woman's family are concerned that her death might have been avoided if the prison and/or other agencies involved at the time leading

up to her death had taken more note of her vulnerabilities, and put in place steps to prevent the risk of self-harm or suicide. In addition to the issue of her children and drug misuse, they make reference to her time in care and domestic violence.

89. I fully acknowledge the family's concerns over the woman's vulnerability based on events both prior to her imprisonment and during her time in custody. Whilst her time spent in care and suffering domestic violence may well have had a significant and enduring impact upon her, it would be unfair to criticise Eastwood Park for not being aware of such information. Unless she had raised these issues as an existing concern during her initial assessments with healthcare, the reception officer or her personal officer, it would be unreasonable to expect prison staff to have known about them. If she had chosen to discuss her vulnerabilities, then the woman would have received a mental health screening and, in the event of showing signs of self-harm or suicidal intentions, an ACCT could have been opened.
90. The prison dealt with the woman's drug misuse appropriately. She also received a full induction on arrival at Eastwood Park to help her settle in. I have criticised the absence of mental health screening that she should have received after her detox. Likewise, I have commented on the absence of timely information sharing between agencies to raise awareness of her past attempts at self-harm and suicide.

The post mortem report

91. The family noted that in the draft report I did not make reference to the post mortem report.
92. My investigator made a request to the Coroner on 8 January 2007 for a copy of the post mortem and toxicology reports when they were made available. These were not sent during the investigation, but were faxed to my investigator at her request on 9 March 2008.
93. In the 'history' section of the post mortem the pathologist says that the woman was told on 5 January 2007 that her children had been taken into care. He also says that "a number of inmates noted a change in her mood" and "just before lock up at 12.23pm she was described as looking into space". It is not clear to me where the information in the 'history' section was obtained. The woman was already aware that her children had been taken into custody and, for this reason, this would not have been news to her. The issue at hand is whether she was told any additional information about the adoption hearing. Despite extensive research, my investigator has not been able to establish who might have told the woman anything about the adoption process. Her parents received a letter from Sandwell Social Services on 19 December regarding the information, but both her family and the Social Services state that the contents were not discussed with the woman herself.

94. With reference to the woman “looking into space”, prisoner A (a prisoner on E wing) told both the police and my investigator during interview that the woman was not her usual self during the morning of 5 January. Prisoner A said that she tried to engage her in conversation but she was not willing. Prisoner A chose not to have lunch that day and so did not see the woman again until she discovered her hanging in the afternoon. It is not clear where the 12.23pm timing has come from.

The passing on of information and records

95. The woman’s family are concerned about the poor exchange of information between outside agencies and the prison, and the impact this might have had on her care.
96. The first area of concern concerns the documentation considered at reception. The police custody record and PER are looked at during the reception process and then kept with each prisoner’s core record. This would have been the case for the woman. No prisoner can be received into a prison without either of these documents. It is bad practice that the cell sharing risk assessment form had not been properly completed to indicate that these documents were seen.

I recommend that the Governor reminds discipline staff of the need to properly complete Cell Sharing Risk Assessment forms, indicating precisely which documents have been seen and received at this stage.

97. As stated in the main body of this report, the woman’s police medical examination record made reference to initial concerns about her being a risk to herself. However, the police had not raised any further suicide and awareness documents to give to the prison. When the woman arrived at Eastwood Park, she was assessed by two members of trained staff as being calm, relaxed, and not presenting as a risk to herself. She was dealt with appropriately given her presentation. The priority was detoxification, which was initiated immediately.
98. I agree that there is no documented evidence of the woman’s previous GP record being obtained. The woman had provided her doctor’s details during her first healthcare screen. The information she gave regarding her medical history (clinical and mental) was cursory. She gave no indication of being at risk to herself at that time or having been so in the past. Neither did she raise any medical concerns beyond her substance misuse.
99. As at most prisons, if medical concerns are raised during this initial screening at Eastwood Park then healthcare would request the previous GP records within the first 24 hours. I agree that it would be beneficial to obtain medical records for all prisoners as quickly as possible after they arrive at prison. However, this is not practical in all cases as many prisoners are not registered at a doctor’s surgery in the community.

100. It is not clear whether having access to the woman's previous notes would have made any difference to the outcome. The woman consistently presented as being as settled as any other prisoner on E wing until she sought the prison GP help on 3 January 2007 for symptoms of depression. On being seen she was immediately placed on antidepressants with a review set for a fortnight's time. The GP remains confident in his assessment that she did not present as being suicidal or indeed at risk of self-harm.
101. The woman's family have asked an additional question regarding the fax sent by the woman's outside offender manager to the prison highlighting her history of self-harm. It is noted that a copy of this fax was resent to an officer at the prison on 8 January. My investigator was asked if she had spoken to the officer about why the document was requested at this time. I understand the fax and any other probation information would have been sent to the prison after the woman's death for the purpose of collating details. I am not concerned that it was resent. However, I remain concerned (as I have said earlier in this report) that the initial fax was not seen or dealt with appropriately the first time round.
102. With reference to communication with social services, the family are concerned that not enough was done to explore the nature of the woman's meeting with a social worker at the prison. My lead investigator established that the social worker with whom the woman spoke on one occasion was the prison social worker. The investigator telephoned the social worker. She quickly established that the social worker had not discussed the adoption proceedings with the woman. The meeting in question was part of the social worker's general visit to E wing with the resettlement team. This was part of a new approach to engaging with the women. Her meeting with the woman was cursory. The woman had asked her to contact her parents regarding her residency order, but did not mention anything to do with her children. The social worker told my investigator that, with hindsight, she regretted not probing the woman for further information. She took the woman's request at face value and did not think there was anything further to be concerned about.
103. The social worker said that she tried to get in touch with the woman's parents but failed. As a result, her message to her parents was not received. The investigator thought there was nothing further to pursue with the prison social worker and so chose not to interview her formally. However, she did make some informal notes of their conversation.
104. The investigator tried at length to find someone at Sandwell Social Services or within Eastwood Park who did speak to the woman about her children. My investigator also spoke to both of her solicitors, neither of whom say they discussed the adoption proceedings with her. No records were requested from social services as this goes beyond the proper remit of my investigation.

The process of ascertaining whether prisoners are a suicide risk

105. The woman's family are very concerned whether training for staff is adequate to ensure the identification and assessment of prisoners at risk of self-harm or suicide. The Assessment, Care in Custody and Teamwork (ACCT) process was rolled out in prisons in April 2005. This replaced the earlier system for identifying and monitoring risk, the F2052 Self Harm form. The ACCT procedure helps all those responsible for a person's care better manage the risk by clearly documenting interactions, observations and assessments, in addition to detailing care plans. The ACCT document is accessible to all involved, both discipline and clinical staff, making care transparent and a shared responsibility.
106. By 1 March 2007, 71 per cent of staff (251 out of 353) at Eastwood Park had been trained in the ACCT process. The training is ongoing, the aim being to have all staff properly trained in the new system. The training includes identifying signs of vulnerability and triggers. However, initiating the process is always going to be heavily reliant on a prisoner's presentation and behaviour. That said, staff do not just rely on what a prisoner is saying. If a prisoner claims to be fine but is clearly behaving to the contrary, then action can be taken. The woman never gave staff any reason to believe that she was not coping until she saw the GP on 3 January.
107. The family question whether the healthcare staff who conducted the first and second healthscreens could have been more probing in their assessments. With regard to the first HCA, I am confident that he conducted an adequate assessment of the woman during the initial healthscreen. As the HCA said in his interview, the woman presented as calm and relaxed. He took note of the fact she said she had harmed herself previously, but she gave no further details and he felt confident that she was not at risk at that time.
108. With regard to the staff nurse, I am confident in her response during interview that the woman gave no information about her problems. If a prisoner does not raise an issue, ask for help or want to discuss a concern, staff can only go so far in probing for information. As the staff nurse explained, the woman said during the healthscreen that she did not have any mental health issues and appeared "quite cheerful". She did not present as vulnerable or at risk. Although the staff nurse said that she had not been trained to assess ACCT documents (this means conducting reviews once an ACCT has been opened), she was comfortable with identifying a need and initiating the process.

The GP's interview

109. In response to the family's question about the GP's assessment of the woman's depression, I refer to the transcript of the interview with my investigator. On pages 5 and 6, the GP explains the conversation they

had regarding her problems. My investigator explicitly asked him how the woman presented during her appointment. He said:

“My memory of that and I kept looking about her notes, she was certainly depressed ... I recall it was her first time in prison. She had a number of, she had I believe five children I think and a number of them had been taken into care and which she found very difficult ... She had a low mood and she described how she was tearful, she just described her appetite as being poor and she had poor concentration, she wasn't sleeping. So clinically she was depressed ... but she did not appear to me at the time to be suicidal”.

110. The investigator asked the GP whether the woman talked at length about her children. He said that he did not make detailed notes, but recalled that she talked about at least one child being in care and was fearful that another might be removed by Social Services. This was all that the woman told him. She made no reference to having received any news about their adoption hearing.
111. The woman's family have asked about the GP's comment regarding whether the “same approach should apply to patients expressing depressive tendencies in a prison context as in the community”. I agree that the prison environment must tend to exacerbate any symptoms of depression. The woman requested and received a doctor's appointment as soon as she raised concerns about her wellbeing. Her symptoms were quickly identified as depression and treated accordingly. Had she displayed any more symptoms of concern, the woman would have been subject to self-harm and suicide monitoring. However, she did not present this level of concern. The GP did set a follow up appointment for her, and she would have been made aware of other support networks within the prison system available to her – the Listeners scheme, Samaritans helpline, and officers on her wing.
112. With regard to the GP's follow up appointment with the woman, my investigator asked him when he would routinely expect to see a patient if he had prescribed antidepressants. He told the investigator that, if he found his patient to be “profoundly depressed,” he would see them again within a week. However, he did not think that the woman presented as “profoundly depressed”. He also said that she would not have experienced a clinical response to an antidepressant in under a fortnight. The medication can take up to eight weeks to become fully effective. I am confident that the GP acted in good faith and took appropriate steps in meeting the woman's needs given her presentation.

Personal Officer scheme

113. In 2003, HM Chief Inspector of Prisons recommended that “a formal and accountable personal officer scheme [be] developed”. Her 2006 report notes that, whilst the scheme was reviewed in September 2005 and a

report produced, there was no evidence of any action taken as a result. There was no policy, and staff received no training in this area. Officers on each wing were designated personal officer responsibility for up to five women. However, in discussions with staff and prisoners (and after examining wing files), HMCIP concluded that very little planned personal officer work actually took place. The quality of informal relationships was good – and, in practice, those prisoners who needed help felt they could approach staff, and these arrangements worked well. However, HMCIP said that she “remained concerned about those prisoners unable or unwilling to seek help in this way”. The continued absence of a formal approach to this work meant that some women still did not receive the help that they needed. The initial recommendation was restated in Chief Inspector’s 2006 report.

114. Personal officer schemes are developed on the basis of local policy as opposed to a centrally defined Prison Service Order. The schemes vary in effectiveness from prison to prison. I agree with the Chief Inspector that the scheme should be more supportive and offer more time to individual prisoners. However, I also acknowledge that staffing pressures at Eastwood Park (and indeed most prisons) mean the role of a personal officer continues to be constrained.

115. The Eastwood Park Personal Officer Scheme Policy and Strategy document provided to my investigator was dated March 2007. Unfortunately, there are no available documents pre-dating this strategy so I am unable to compare this with previous personal officer requirements. My investigator was told that no copies were kept. The 2007 document states that the role of the personal officer is:

“... the focal point and point of referral and support for all prisoners in our establishment. This role is not confined to formal interviews or reports as effective personal officer work is often carried out during routine activities throughout the core day. This type of interaction plays an important part in influencing prisoner’s behaviour, fostering positive relationships and demonstrating our high level of care.”

The duties listed are:

- Introduce yourself to those prisoners you have responsibility for
- Explain the role of the personal officer
- To assist in dealing with any initial issues or concerns
- Building relationship through formal and informal interviews
- Keep yourself informed of any relevant matters
- Keep abreast of any change in circumstances
- To be the first in line of contact when any problems arise
- Encourage contact with family/friends/outside agencies etc.
- Challenge negative or disruptive behaviour

- Encourage them to address offending behaviour and to seek professional help from support agencies
- To liaise with support within the establishment
- To make regular entries and log all relevant information in the F2052A wing file [also known as a history sheet]
- To attend review boards as required
- To encourage all prisoners to take part in the regime and activities available
- If available take part in the induction process

113. The woman's personal officer, said in her interview for this investigation that, beyond the initial introduction, the scheme relied on the prisoner herself being proactive. The officer said that, if a prisoner under a personal officer's responsibility was subject to an ACCT, they would be monitored more closely. She told my investigator that the standard for minimum contact levels between a personal officer and a prisoner was once a fortnight. Interactions are supposed to be recorded in the prisoner's wing file (history sheet). There is no record of the officer's contact with the woman in her wing file. I would expect to see at least one entry recording that the second wing officer had introduced herself to the woman.

The Governor should remind personal officers of their responsibility to record contact with prisoners in wing files in accordance with the 2007 Personal Officer Scheme Policy and Strategy.

Interview with the Head of Healthcare

114. The woman's family asked why the interview conducted by my investigator with the head of healthcare was not tape recorded. I understand the interview was not pre-planned. It began as a general conversation and my investigator then decided to write a formal record of the discussion. My investigator thought it sufficient to keep an agreed summary of the conversation with the Head of Healthcare. The format for recording an interview is at the investigator's discretion. I accept both summaries of interviews and transcripts as evidence.

Lesson learning from previous deaths in custody

115. Before conducting the investigation, the investigator read through other death in custody reports for Eastwood Park produced by my office. Those investigations did not reveal similar circumstances to the woman's case, and the recommendations made were not pertinent to this report. Neither my investigator nor I were aware of the death of a young woman on D wing in 2000 during the course of writing the draft report. The investigation in 2000 had been undertaken by a senior investigating officer (SIO) from the Prison Service. My office did not take formal responsibility for investigating deaths in custody until April 2004.

116. On reading the SIO's report, I am surprised that the similarity in circumstances was not raised by anyone at Eastwood Park. I am grateful to the solicitor representing the woman's family for bringing it to my attention. I reiterate some of the salient points and recommendations regarding the young woman's care at Eastwood Park below.
117. Like the woman, the young woman had used the metal hinge on the cell wardrobe to suspend a ligature. A design feature of the wardrobe is that it has four metal hinges. As a result of the investigation into the young woman's death, it was recommended that the hinges be removed thus reducing the number of potential ligature points in each cell. It was also recommended that, "cell wardrobes in each D wing cell to be risk assessed with a view to the removal of all ligature points". I would recommend that this risk assessment be extended to all cells on all wings.

I recommend that the Head of Residence risk assesses the wardrobes in all cells with a view to removing potential ligature points.

118. Another problem identified in the SIO's report into the earlier death was the height of the privacy screen in each cell. The screen restricts observation of the sanitation area from outside of the cell. However, whilst I appreciate that this does make observations more difficult, there is a balance to be struck between human decency and risk management. I endorse the recommendation made in the SIO's report that, "staff should have clear guidelines on gaining an appropriate response from prisoners during roll check." As stated earlier in this report, where staff are unable to make a visual check through the observation panel they should make sure they get a verbal response.
119. Like the woman who is the subject of this report, the young woman who died in 2000 had also been registered as at risk of self-harm and suicide at her probation office. The probation report was forwarded to Eastwood Park but was not formally followed up. This has echoes in the lack of documented follow up in the woman's circumstances. The SIO report recommended that, "the procedure for passing on probation and welfare concerns raised by outside practitioners should be reviewed". As I have said earlier, I would like to see relevant agencies (Social Services, Probation, Prison) work together more closely in highlighting and addressing the needs of women prisoners.

HM Chief Inspector of Prisons' Report, March 2006

120. The woman's family has drawn my attention to recommendations in the Chief Inspector of Prisons' 2006 report regarding:
- Staffing levels on E wing
 - Lesson learning from previous deaths

- Information sharing with outside agencies
- Greater liaison between primary mental healthcare and the mental health in-reach teams.

My investigator has looked at the context of the recommendation on reviewing staffing levels on E wing with regard to prisoner safety. The Chief Inspector's report states that in 2006 some prisoners reported that they felt unsafe on the wing, and there were a number of serious assaults. A recommendation to review staffing levels had been made in 2003 and still had not been fully addressed by 2006. The Chief Inspector restated the need for this to be addressed. However, whilst I agree that this is an important matter, the question of safety on the wing is not something that emerged as an issue for the woman. There was no evidence to suggest that she felt unsafe or bullied, and for this reason my investigator did not pursue this issue with the prison.

121. The Chief Inspector's report comments on lessons learned from previous deaths in custody at Eastwood Park. A recommendation had been made in the earlier inspection report to conduct an analysis of all deaths in recent years to see what, if any, significant similarities there were and what lessons could be learned. The Chief Inspector's 2006 report said this had not been done. Individual action plans had been drawn up for isolated incidents, but there had been no systematic review of the deaths to identify recurring recommendations and ensure that the planned action had been implemented and sustained.
122. I agree that an analysis of the kind proposed by the Chief Inspector would be helpful.
123. The reference to "greater liaison between the healthcare centre mental health staff and mental health in reach team" in the Chief Inspector's report focuses on a lack of communication between the two teams for prisoners under their care. I agree that this would have been pertinent if the woman had been identified as a prisoner who required mental health intervention and was receiving it. However, she was not under either the primary mental healthcare team or the in-reach team. My report highlights that she missed the mental health screen that should have taken place after her detoxification. I have covered this matter elsewhere in this report and a recommendation has been made.

RECOMMENDATIONS

The Head of Healthcare should ensure that staff responsible for generating mental health assessment appointments after a detoxification programme are clear of their responsibility.

The Prison Service accepts this recommendation. By 30 January 2008, the Head of Healthcare will ensure that procedures for generating appointments for mental health assessments and referrals following the completion of a detoxification programme are clarified with all staff responsible for generating appointments.

The Governor should remind officers that during all checks on prisoners they should receive either a visual or verbal response.

The Prison Service accepts this recommendation. By 30 December 2007, the Governor will remind managers of the “good practice in obtaining visual or verbal responses at unlock.”

ADDITIONAL RECOMMENDATIONS AFTER DRAFT CONSULTATION

I recommend that the Governor reminds discipline staff of the need to properly complete Cell Sharing Risk Assessment forms, indicating precisely which documents have been seen and received at this stage.

The Prison Service accepts this recommendation. The Violence Reduction Policy is being reviewed as part of the implementation of the new policy. Staff training will be offered and guidance issued with their Staff Performance and Development records (SPDRs). The target date for completion is July 2008.

The Governor should remind personal officers of their responsibility to record contact with prisoners in wing files in accordance with the 2007 Personal Officer Scheme Policy and Strategy.

The Prison Service accepts this recommendation. By June 2008, the Residential Governor will issue a Notice to Staff to remind them of Personal Officer Schemes and that staff should make a weekly entry in prisoners' files, and should attend ACCT reviews or make a written contribution.

I recommend that the Head of Residence risk assesses the wardrobes in all cells with a view to removing potential ligature points.

The Prison Service partially accepts this recommendation. A risk assessment will be completed following an analysis of all deaths in prison custody within the women's estate over the past five years. The Prison Service highlight, however, that these cells are not designated safer cells and there are numerous ligature points. The target date for completion is end of June 2008

