

**Investigation into the circumstances surrounding the  
death of a woman at HMP Peterborough  
in January 2007**

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

**May 2010**

This is the report of an investigation into the death of a woman at HMP Peterborough in January 2007. She was discovered lying unconscious on the floor of her cell with a ligature around her neck. Although known to be at risk of self harm or suicide, she had not been checked regularly by the auxiliary officer on night duty. The officer has since resigned his post.

Efforts were made to resuscitate the woman to no avail, and she was pronounced dead in her cell by paramedics. She was 28 years old.

I offer my sincere condolences to the woman's family who have endured a long and painful wait for the police investigation to be completed, the Crown Prosecution Service to deliberate, and for my investigation process to reach its final stages. I am only too conscious of the considerable time between her death and the production of this report. I must apologise to her family and all those touched by her death for that delay. I am grateful to her parents for their unstinting patience, and I hope this report helps provide a clearer understanding of the events leading up to their daughter's death and its aftermath.

The investigation was led on my behalf by one of my senior investigators assisted by another senior investigator. One of my Family Liaison Officers has remained in contact with the woman's family.

I would like to thank a member of the Strategic Health Authority for his assistance in co-ordinating the involvement of various teams to secure appropriate healthcare input into this investigation. I am also grateful to two independent healthcare practitioners and the Consultant Forensic Psychiatrist, who conducted an independent clinical review of the healthcare the woman received whilst in custody.

My thanks also go to the Detective Chief Inspector and Police Constable of Cambridgeshire Police for their willingness to share information. I am indebted too to the Director of HMP Peterborough for the co-operation of his staff and, in particular, the Business Development Manager who handled liaison with my office.

The woman was the first and, to date, only person to have died apparently at their own hand at Peterborough (a prison that holds both male and female offenders) since it opened in 2005. In common with most prisons for women, its population includes many vulnerable women with complex needs and amongst whom repeated attempts of self-harm are sadly only too common. The woman shared some of the vulnerabilities identified in a report on women in the criminal justice system, published in March 2007. Significant mental health problems had dogged her life prior to imprisonment and did not stop beyond the prison gate. She suffered physical health problems and also had a history of disturbing, severe and prolific self-harm – all facets noted by the author of the report in calling for a woman-centred approach to woman offenders. She spent three periods at Peterborough, being recalled on two occasions. Under Multi Agency Public Protection Arrangements (MAPPA), she was classed as a high risk (level 3) offender, the highest level of risk.

This is a report that I hope will be widely read by those in the Prison Service with responsibility for women's prisons and those involved in the commissioning of new prisons. The independent clinical review makes 25 recommendations concerning

healthcare and caring for prisoners at risk of self-harm or suicide, and highlights four points of good practice. I endorse them and add ten recommendations concerning ACCT, clinical care and family liaison.

Given the extent of the woman's self-harming, it is difficult to see how Peterborough could have totally eliminated the risks to her life. However, opportunities to reduce them were missed as a result of what I judge to have been systemic failures.

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

**Jane Webb**  
**Acting Prisons and Probation Ombudsman**

**May 2010**

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## SUMMARY

Before the woman came into custody, she had a history of mental ill-health and self-harm going back several years. She had been diagnosed as suffering from Emotionally Unstable Personality Disorder. She was voluntarily admitted to psychiatric hospital when she was 20 and began to harm herself by making cuts to various parts of her body. She also suffered from a benign pituitary gland brain tumour which manifested itself in physical health problems for which she was required to take a number of medications.

HMP Peterborough was opened in March 2005. The woman was first remanded in custody to Peterborough on 5 June 2005, charged with sending a mobile telephone text message that said she wanted to kidnap and drown a child. She pleaded guilty and was sentenced to two years imprisonment on 23 July. Whilst at Peterborough, she was referred for a mental health assessment and placed on F2052SH measures to monitor and support prisoners who are at risk of self-harm or suicide. (This procedure has since been superseded by Assessment, Care in Custody and Teamwork (ACCT) which provides a more multidisciplinary approach to supporting prisoners through a period of crisis.)

The woman's parents were concerned that she was not being prescribed the correct medication for her illnesses. On more than one occasion, they asked her clinician to write to the prison to ensure that she was receiving appropriate medication. At Peterborough, she harmed herself more than 50 times, using methods such as self-strangulation, swallowing objects, jumping from height, inserting items into body orifices, and cutting herself. After serving a year of her sentence, she was released on licence on 1 June 2006.

On 21 July 2006, the woman's conditional release licence was revoked because she had failed to live at an address approved by her supervising probation officer. She was arrested the next day but, whilst in a police cell, tied a ligature made out of her socks around her neck. She was discovered by a police officer and told him she wanted to die as she could not face returning to prison for a year. She then admitted having taken 32 sedative tablets before her arrest and inserting a hairclip into her anus. She was taken to hospital for treatment. While there, she tied another two ligatures around her neck and attempted to suffocate herself by putting cardboard down her throat. On 23 July, she was recalled to Peterborough. She was placed on an ACCT plan after she began to self-harm by cutting herself with a razor blade, picking at the wounds she had created, and putting objects into her body.

The Parole Board decided that the woman could be released on 25 September 2006 provided that her supervision in the community was increased. She was required to address her previous alcohol misuse and have weekly appointments with her probation officer and community psychiatric nurse.

The woman was recalled to Peterborough for a second time on 7 December 2006 as her probation officer was concerned that her behaviour had become extremely unpredictable and that she might act in a manner which could endanger herself and others. She was arrested at hospital after assaulting staff who had tried to prevent her tying a ligature around her neck. She was kept under constant observation by

the police and arrived at Peterborough with a warning form that she was a high suicide risk and would attempt to take her life. In response, an ACCT plan was opened on reception by Prisoner Custody Officer (PCO) A. She told the PCO that she did not feel in the right frame of mind for an assessment and asked if it could be postponed until the next day. The Immediate Action Plan part of the ACCT plan was only partially completed by Senior Prisoner Custody Officer A (SPCO) and no arrangements were made for her to be assessed or have a case review until three days later (actions which should have taken place within 24 hours). In addition, she did not have a mental health assessment. The frequency for observing her was set at twice an hour with four conversations with staff during the day.

On 14 December, the woman applied to be released on temporary licence to attend the funeral of her grandfather who had died a couple of days earlier. Her request was turned down. She continued to harm herself, on one occasion cutting a wound in her stomach and inserting pens into it.

At the end of the month, on 30 December 2006, the woman was issued with a Notice of Report under the prison disciplinary system when medication wrapped in paper was found in a flask during a search of her cell. The adjudicator adjourned the hearing so that the PCO who placed her on report could attend and read out his evidence.

The woman pushed a note under her cell door to the night auxiliary officer (AO) on 7 January 2007 saying that she was going to kill herself on 12 January. That evening she was observed by the night AO lying on the floor of her cell but she was breathing.

The woman's partner in the prison was transferred to HMP Holloway on 11 January as part of her sentence progression. The woman was very upset and spent most of the morning crying.

The adjourned adjudication hearing resumed the next day. The woman pleaded guilty and told the adjudicator, the Deputy Controller, that she had secreted the medication with the intention of taking an overdose so that she could kill herself. She said she had made the decision once she had been denied permission to go to her grandfather's funeral. She also told the Deputy Controller that she had tried to cut off her breast.

The Deputy Controller was very concerned by what the woman had told her. She contacted a number of senior prison staff, including the Director, to alert them to the situation. Her ACCT was reviewed that evening by SPCO B but she decided to keep the observation levels unchanged at twice per hour.

At 11.00pm in January, the woman was discovered by a night AO lying on the floor of her cell. She was unconscious and was not breathing. An ambulance was called. Despite the efforts of healthcare staff, officers and paramedics, they were unable to resuscitate her and she was pronounced dead at 11.45pm. The night AO was suspended from Peterborough and admitted later to the police that he had not seen her after the handover from day staff at 8.15pm. He had not observed her twice an hour as he was supposed to do. He resigned his post at Peterborough.

A police investigation took place into the circumstances surrounding the woman's death. The evidence they gathered was passed to the Crown Prosecution Service (CPS) to consider whether criminal charges should be brought. The CPS decided that, although the night AO had "wilfully neglected to perform his duty without reasonable excuse" there was insufficient evidence on which to base a realistic prospect of conviction for an offence of misconduct in public office or gross negligence manslaughter.

This has been a complex investigation which has taken many months to complete. The independent clinical review that accompanies this report is critical of many aspects of physical and mental healthcare. I also make a number of recommendations in this regard. In particular, I have been struck by shortcomings in the provision of healthcare at Peterborough. I believe that the healthcare the woman received was not of a similar level to that she would have received in the community. I also make recommendations concerning the operation of the ACCT process for prisoners at risk of self-harm.

## THE INVESTIGATION PROCESS

1. When a death occurs in a prison, the police attend and examine the area where it happened to determine whether the circumstances require further investigation. In line with a Memorandum of Understanding between the Prisons and Probation Ombudsman's Office (PPO) and the Association of Chief Police Officers, the police investigation has primacy, insofar as this is necessary to ensure that my investigation does not prejudice any criminal investigation or the fair conduct of any subsequent legal proceedings.
2. Following the woman's death, Cambridgeshire Police carried out an investigation led by a DCI. As a result an officer of the Special Crime Division of the Crown Prosecution Service considered whether charges of gross negligence manslaughter and misconduct in public office would be appropriate. Although he was satisfied that an auxiliary officer breached his duty of care towards the woman, he concluded that it was impossible to say, to the criminal standard, that the breach of duty in checking her represented more than a minimal contribution to the cause of death. He concluded that there was insufficient evidence on which to base a realistic prospect of conviction.
3. My investigator was given access to the woman's current prison records including her clinical records, CCTV records and documentation gathered by Cambridgeshire Police. However, important documents recording concerns about her self-harm and complaints she may have made during her previous periods in custody, which could have assisted my investigator, could not be located. My investigator visited Peterborough on two occasions and, accompanied by another senior investigator, conducted a number of recorded interviews over two days, familiarised herself with the layout of the prison, and observed staff at work. My investigators provided feedback to the Director after completing the prison interviews. Some of the staff involved in the woman's care no longer work at Peterborough and my investigators were unable to locate them for interview.
4. Notices to staff and prisoners announcing the investigation were displayed around the prison. No written responses were received, but two former prisoners contacted the Mental Health NHS Partnership Trust to say they had concerns about the lack of medical and mental health care offered to the woman. The Trust passed these to the Parliamentary and Health Service Ombudsman who in turn forwarded them to my office. Regrettably, I did not receive replies from the women concerned. The charity INQUEST forwarded the details of two persons (one who had also contacted the NHS Partnership Trust) who had contacted them on learning of the woman's death. Unfortunately, I did not receive responses from them either.
5. My investigator and one of my family liaison officers met the woman's parents to explain the purpose of the investigation and offer the opportunity to raise relevant issues. They shared their concerns about what they described as very unsatisfactory health support that she received before she was taken into custody. In relation to her life prior to being recalled to custody, they felt that

the lack of adequate resettlement support played a part in her subsequent return to prison. They were disappointed and frustrated by the CPS decision not to bring criminal charges against staff at Peterborough and, in particular, against the prisoner custody officer who was on duty on the unit when she died. Her parents wanted to know what changes had been made concerning the monitoring of prisoners at risk of self-harm and suicide. They questioned the attitude of certain members of staff to her and said that she had felt bullied by one member of staff. When raising the issue that she had not received important legal correspondence that they had forwarded to her, they felt that their concerns had been met with indifference. Her parents were also concerned about the healthcare she received, particularly the difficulties she had experienced in getting appropriate treatment for her pituitary gland brain tumour and the management of her incontinence. Her parents felt the prison and the Primary Care Trust seemed to adopt separate and independent attitudes regarding healthcare and that there was a distinct lack of continuity between the two. Of concern to them also was how she had been able to stockpile medication. They believed that her death was both foreseeable and preventable.

6. After they had been told by the police of the woman's death, they were deeply distressed to find details on Teletext ahead of being given any information by the prison. Beyond the first contact with Peterborough's family liaison officer, they felt they were left to chase the prison for contact.
7. I have done my best to address all the issues raised by the woman's parents in my report. Following the issue of my draft report, her parents wrote to me with their concerns and feelings regarding the whole investigation process. I have taken the unusual decision to publish their letter as a new annex to this Final report. I hope the findings of my investigation have helped them gain a better understand of the events leading up to their daughter's apparent suicide.

## **HMP PETERBOROUGH**

8. HMP Peterborough is the first purpose-built prison to hold women and men and the newest prison in England and Wales. The two halves of the prison are completely separate though they occupy the same site and share some staff. Opened during Easter 2005, Peterborough is privately-managed by Kalyx under a 25 year contract.
9. The Director is responsible for managing the prison. A Controller (and deputies) are employed by the National Offender Management Service in all private prisons to monitor the contractor's compliance with the terms of the contract. The Controller can impose financial penalties if the prison does not meet its performance targets. At the time of the woman's death, Controllers were also responsible for conducting adjudication hearings into alleged breaches of prison rules. (Those duties have since been passed to the Director, in line with public-sector prisons where the Governor (or delegated staff) conducts adjudications.)
10. Peterborough's women prisoners come from a large area that spans much of the Midlands, the Fens and East Anglia, as well as transfers from other prisons. The woman is the only prisoner to have died, apparently at their own hand, since the prison opened.
11. Peterborough holds up to 384 adult women and young offenders on remand or serving a full range of sentences up to and including life imprisonment. The residential accommodation consists of two two-storey houseblocks, each containing five wings in a radial pattern off a central hub. There is a separate self-contained Mother and Baby Unit and an in-patient healthcare centre. CCTV provides comprehensive coverage of residential areas and corridors. At the time of her death, houseblock 1 held unconvicted prisoners and houseblock 2 was for convicted (this arrangement has been altered since her death).
12. At the time of the woman's death, the Primary Care Partnership had commissioning responsibility for some healthcare services. It was also the provider of primary nursing and associated administration until February 2008 when Kalyx took over these services. Commissioning mental health in-reach and secondary care remain the responsibility of the NHS.

### **Reports by HM Inspectorate of Prisons**

13. Her Majesty's Chief Inspector of Prisons carried out an announced inspection on 2-6 October 2006 which was published in February 2007. The report of the inspection described Peterborough as "an extremely complex establishment to manage, and, as a local prison, at the sharp end of prison overcrowding and population pressure". Whilst acknowledging that Peterborough had survived its first 18 months without the serious disorder which often befalls newly-opened establishments, the inspection "revealed some fundamental weaknesses and problems, both with the contractual

arrangements and with the actual running of key services, which left prisoners and managers extremely exposed”.

14. The report went on:

“Health services were justifiably the major complaint of most women prisoners. Services delivered by the local primary care trust (PCT) were very poor ... Record keeping was poor and fragmented and we found a number of serious deficiencies in the management and administration of medicines. There was a lack of trained health staff for inpatients and most care was provided by prison custody officers. There were no clear criteria for admissions. Many locum GPs were used, with a consequent lack of continuity and quality of care for prisoners. Women were unaware they could request to see a woman GP and the appointment system was poor. There were serious shortfalls in the provision of physical care ranging from lack of routine attention to dressings to delays in being assessed for potentially serious conditions.

“One of our main concerns was the provision of healthcare, which was among the worst we have seen for some considerable time. At every level – from the administration of medicines, through to primary and in-patient care – there were serious deficiencies, with under-trained and inadequately managed healthcare staff unable to provide a safe and decent service. These defects were so serious that we called in senior managers from Kalyx and the NHS to take immediate remedial action.”

15. Although the healthcare centre was on one level and was accessible to prisoners with limited mobility, there were no care plans for disabled prisoners and a lack of suitable facilities.

16. In respect of prisoners at risk of suicide or self-harm, the Chief Inspector commented:

“We also found some worrying deficiencies in the operation of safer custody procedures ... the high level of self-harm among women prisoners had initially come as a shock to many staff. While they had been trained in the new, multi-disciplinary suicide and self-harm prevention system, we found that it was poorly implemented: with support procedures not put in place when they should have been, and closed off without proper review. Care plans were too often weak. Some innovative services had been introduced to support vulnerable women but they were underused, and too many mentally ill women were held in the separation and care unit.”

17. The report welcomed the fact that most prisoners were allowed out of their cells more regularly than in other prisons (although there was still insufficient purposeful activity), and recognised the quality of the prison’s management and the positive approach of staff as strengths. However, it found that:

“... the inexperience of staff, and the relatively light staffing levels, meant that they were often unable to deal effectively and swiftly with prisoners’ complaints and needs. There was little evidence of proactive personal officer work, or work to encourage prisoners to deal with the causes of their offending.”

18. The inspection identified three underlying problems that were hampering progress at Peterborough. First, it felt that the contract to manage the prison needed to be re-examined as it had been drawn up some years before the prison opened and included incentives which did not match the prison’s actual needs. Secondly, lack of supervision and support at a regional or national level meant that the prison, in the areas of healthcare and suicide prevention, was in danger of “drifting away from good practice”. Thirdly, the male prisoners were dominating the prison to an extent that the needs of the women were being overlooked. The Chief Inspector concluded that “all policies and processes need to be re-examined in the light of specific needs of women, and in most cases separate policies developed.”

19. The Chief Inspector’s report listed 11 recommendations concerning self-harm and suicide. These included:

“... the self-harm and suicide prevention meeting should analyse and discuss the data provided on incidents of self-harm and the operation of ACCT procedures to improve the care of women at risk. More qualitative measures drawing on women’s experience of the procedures should be developed.

A clear definition of a serious or near fatal incident should be developed and a formal investigation procedure instigated in order to learn from such incidents.

There should be improved management checks of the quality of ACCT procedures and these should include talking to women at risk about their experience of their care.

Listener recruitment and training should anticipate the release and transfer of trained Listeners to ensure a viable scheme.”

20. A healthy prison is defined by the Inspectorate using four criteria: that prisoners are held safely, treated with respect for their human dignity, are able and expected to engage in activity that is likely to benefit them, and are prepared for their release and helped to reduce the likelihood of re-offending. Two recommendations were made in the report’s Healthy Prison Summary concerning suicide and self-harm. The first said:

“A safer custody strategy specifically for women should be established covering all aspects of safety and involving women prisoners to help ensure a generally safe environment and improve support and care for those at risk of self-harm.”

The other was that there should be a dedicated safer custody co-ordinator for the women’s prison.

21. An unannounced short follow-up inspection of Peterborough was conducted between 30 June – 4 July 2008. The inspection report:

“... found improvements in relation to safety and activity, and also found that there had been attempts to create a separate management structure and distinct procedures for the women’s prison.”

In relation to support for women at risk of suicide and self-harm, the report said:

“... though procedures to support women at risk of suicide had improved, levels of self-harm were high and available resources were not effectively targeted. The separate policy document for women was in fact an identical copy of the policy in the men’s prison ... Staff-prisoner relationships were not positive, with little interaction or support for women prisoners from relatively inexperienced officers, a high proportion of whom were male. Women had little confidence in applications and complaints systems ... Healthcare had improved, but there remained much to be done, and primary mental health services were under-resourced.”

22. The report commended the progress made since the previous inspection and acknowledged that Peterborough was performing reasonably well in the areas of safety and activity. It concluded, however, that in contrast to the previous inspection when staff-prisoner relationships were seen to be positive and relaxed:

“... there remained weaknesses in the crucial area of staff-prisoner relationships, and insufficient focus on the specific and different needs of a diverse female population.”

23. With regard to the two Healthy Prison recommendations, the safer custody strategy specifically for women had not been achieved but a dedicated safer custody co-ordinator and a deputy were in post.

### **Reports by the Independent Monitoring Board**

24. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board’s role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. The report by Peterborough’s IMB dated April 2006 to March 2007 covered both the men’s and women’s prisons. It raised three main areas of concern. First, it said that the healthcare centre “failed to meet an adequate standard of care for the prisoners” and that healthcare should be commissioned by the local Primary Care Trust. It accepted that the Chief Inspector had been very critical of the healthcare provided and described her report as fair. Secondly, it called for the establishment of mental health units to cater for “a very high and unacceptable level of mental health issues ... a much greater pro-active plan should be set up to help the many offenders with personality disorders”. The

IMB report said more than 70 per cent of prisoners suffered from mental health problems. Thirdly, it recognised that most prisoners stayed for short terms (women for an average of five weeks) and called for “a change in ethos to more preparation for return to the community”. The report acknowledged that a major review of regimes was being undertaken.

25. The most recent IMB annual report available (1 April 2007 - 31 March 2008) noted several improvements in the areas of healthcare and mental health. These are described later in my report. Regarding suicide awareness and self-harm, the IMB was satisfied that the ACCT system was working well and noted that diligent staff of all grades saved many prisoners' lives.
26. Independent clinical reviewers who examined the woman's care whilst in custody spoke to staff who had been at Peterborough since it opened. They described it as a busy and challenging place to work. Healthcare staff turnover had been rapid initially and sickness levels were described as high. There were a significant number of locum general practitioners leading to a lack of consistency, and there were three healthcare managers between March 2005 and February 2008. The clinical review found a lack of guidance on the role and responsibilities of Primary Care Trusts in relation to contracted out prisons.

## KEY EVENTS

27. In 2005, the counsellor mentioned in paragraph 13 above (who was alleged to have had a relationship with the woman whilst she was in hospital) reported to the police that she had sent several text messages to his telephone. One of the messages on 23 March 2005 said that she wanted to kidnap a child, take it to a hotel in London and drown it in the bath.

### **The woman's first period at Peterborough – 2 June 2005 to 1 June 2006**

#### ***As an unconvicted prisoner***

28. The woman was arrested on 1 June 2005 and charged with threats to kill an unknown child. She was remanded in custody at Magistrates Court and taken to HMP Peterborough on 2 June. Peterborough had been open for approximately three months. On reception, she was interviewed by Healthcare Worker (HCW) A concerning her health history. The woman said that she was suffering from shingles and a brain tumour. She gave a list of the medications she was taking – Bromocriptine (which acts on the pituitary gland to block the production and release of growth hormone); Spironolactone (a diuretic); Quetiapine (an anti-psychotic drug which has a calming effect); Citalopram (an anti-depressant used for depression or panic attacks); Diazepam (which has a sedative and anxiety-relieving effect); Zopiclone (used in the short term treatment of insomnia) and Metformin (used for conditions where there is insulin resistance). She said she used cannabis weekly. Asked if she had any concerns about her physical health, she said that she had suicidal thoughts and was very depressed. She was also worried about her brain tumour. HCW A wrote on the First Reception Healthscreen form of her appearance: “very calm, relaxed, no injuries noticed, but did show burn on her arm from self-harming, no medical treatment required”.
29. The woman gave details of her contact with mental health services at hospital. She said that she had tried to harm herself in March and left her with burns to her left forearm and right knee. Asked if she currently felt like harming herself, she replied that she did. HCW A wrote in the section of the form which asks for an impression of the prisoner's behaviour and mental state: “feels suicidal at the moment, but not cutting. Feels like burning herself.” The box “Refer for mental health assessment” was ticked and “open F2052SH”. She was placed in the healthcare centre on half-hourly observation.
30. The next day, the woman saw a doctor (whose signature is illegible) who recorded her mood as “generally well, moderately anxious and mildly depressed”. An entry in her Mental Health In-reach Team record by Nurse Practitioner A on 5 June reads:

“Referral from Healthcare. Depression and Borderline Personality Disorder. DSH [Deliberate Self Harm] set fire to herself – has made threats to kill children. Is being treated for a brain tumour. Not seen – staff report an improvement since referral.”

Also on 5 June, Registered General Nurse (RGN) A wrote in the woman's clinical record: "seen in Healthcare – she says that she is not allowed to walk more than 100 metres and not allowed to go upstairs!"

31. Partially completed forms for the Care Programme Approach (CPA) from the Mental Health Partnership NHS Trust were at the front of her Mental Health In-reach Team record. (CPA is a method of managing patients with complex mental health needs. There may be involvement by medical, social work, housing and mental health professionals. It requires multi-disciplinary assessments and care plans which are reviewed at regular intervals.) At the back of the record was a CPA Risk Screen completed by Nurse Practitioner A on 5 June which judged the risk of suicide/deliberate self harm as medium.
32. The woman's clinical record was updated on 6 June by a member of staff from the In-reach Team (whose signature is illegible) who wrote that her referral had been taken. That day, she saw a doctor who listed her problems and the medications she was taking in her clinical record, and prescribed medication to last 28 days.
33. On 7 June, a partially-legible entry in the woman's clinical record appears to say that she had no thoughts of self-harm. She was moved from healthcare to A wing, a residential houseblock.
34. According to the woman's clinical record and a self-harm chart compiled by the police, she called a night officer to her cell on 12 June. She said that she had been banging her head against a wall as voices in her head were telling her to harm herself. On 13 June at 1.00am, RGN B wrote in the woman's clinical record that she was seen by a member of staff on nights with a swelling on her cheek and eye area. She said she had punched herself in her right eye. RGN B placed her on an F2052SH with observations to take place three times an hour.
35. A pre-sentence report on the woman was written by a probation officer on 20 June. The report said that she admitted sending the text messages that had led to her prosecution. Her defence was that she was an in-patient at hospital at that time and was psychotic. She explained her motivation for committing the offence as sexual attraction to female children and alleged that she had herself been sexually abused. Murdering a child, she said, would make her feel powerful instead of feeling like a victim. She went on to say that she felt she might steal a child because she would have liked to re-live her childhood and that she had tried to abduct a child on two previous occasions.
36. The probation report refers to a forensic psychiatric report written in March 2005 by a hospital psychiatrist. In his report (which I have not seen), the woman was diagnosed as suffering from Emotionally Unstable Personality Disorder, Borderline Type. She also suffered from "psychotic episodes such as pseudo hallucinations and depressive symptoms and has a low tolerance to frustration and a low threshold for aggression, impulsivity and anger". The psychiatric report alluded to her previous behaviour that indicated risk of serious harm. It said that in 2000 she had admitted trying to kill her mother by

putting paracetamol in her food. Also in 2001 she threatened another hospital patient with a knife. In 2003 she told a doctor that voices were telling her to kill her ex-drama teacher, and in 2004 she set fire to her flat.

37. On 21 June 2005, Nurse A from the In-reach Team wrote in the woman's clinical record that she would arrange an appointment for her. An update in the clinical record the next day from another member of the In-reach Team (again, signature illegible) said that arrangements had been made to see her on 23 June on her wing.
38. However, the woman attended the magistrates court on 23 June and was unable to attend the appointment with the In-reach Team. She pleaded guilty to the offence of threatening to kill a child.
39. The woman's clinical record showed that she was seen on 30 June by a member of the In-reach Team (although the session was not recorded in her In-reach record). She was described as "articulate, good insight into her behaviour and sees herself as a danger to others especially children". A follow-up appointment to alter the dose of her medication took place on 4 July and was noted in the in-reach record.

#### ***After conviction 13 July 2005 – 1 June 2006***

40. On 13 July 2005, the woman was sentenced to two years imprisonment. She was issued with a Sexual Offences Prevention Order which prevented her from having contact with children under the age of ten.
41. During the period that the woman spent in Peterborough, she harmed herself more than 50 times – using a variety of methods and with increasing intensity. I list each episode here and then go on to describe other events in the same period.
42. On 14 August, the woman spilt hot water on her legs, on 28 August she swallowed a pen lid, and on 6 September she attempted to jump from an upper floor and had to be restrained by staff. At a cell check on 8 September she was found with a plastic bag over her head, and on 16 September she put paper down her throat. She tried to strangulate herself with a jumper on 29 September and then tried to force pieces of polystyrene cup down her throat.
43. On 3 October, whilst in the healthcare day room, the woman tied an aerial around her neck and pushed paper from the guinea pig's cage down her throat. A month later on 3 November, she swallowed a tampon, and on 7 November she tried to make a ligature using her pyjamas, cut her arms and legs and superficially burnt herself with a cigarette. She tied a ligature around her neck made from a pair of jeans and climbed on top of a wardrobe, all on the same day. On 11 November, she inserted a knife into her anus, on 23 November, she was found choking after swallowing some plastic. She tried to drown herself in her cell washbasin on 3 December.

44. The next episode was on 28 April 2006, when she was found to have a pen wedged in her anal pouch. On 28 May, she cut her stomach in a wound two centimetres wide, the next day she put a razor blade into the stomach wound.
45. Two weeks after being convicted, on 1 August 2005 the woman was re-admitted to healthcare as she was suffering physical symptoms relating to her hormonal illnesses. Her right breast was very painful, and described as hot with a large lump. She was referred to see a consultant on 5 August at hospital.
46. The woman was seen in healthcare by a member of the In-reach team on 3 August. A note of the session (signature unclear) reported her as saying she was hearing voices, but there was no evidence of that during the meeting. She complained about being on the second floor and that the prison was discriminating against disabled people.
47. On 4 August, the woman's mother went to see the woman's endocrinologist (a medical professional who specialises in the treatment of hormone-related disorders) at hospital. The doctor wrote to Peterborough that the woman's mother was in a very distressed state. She had said that the woman had not been given any medication for more than four weeks, leading to a deterioration in her condition. He wrote in a letter received by healthcare on 30 August  

"I think it is important to let you know that this lady [the woman] does need some dopamine agonist, however she needs to have her dose built up gradually because of the previous psychotic reaction ... but as she is very tolerant of Bromocriptine at increasing doses it is important that she continues with these."
48. The woman's parents told my Family Liaison Officer that they wrote several letters to Peterborough outlining their concerns about her lack of treatment. They felt they had been labelled as over-anxious parents and that this had back-fired on the woman who had received "jibes" from staff because her parents had written querying her care. Notwithstanding the endocrinologist's letter, they said that the woman continued to experience problems with her medication. Sometimes the dosage would be insufficient or, if she was asleep, no effort would be made to give her the tablets she had missed.
49. The woman attended her hospital appointment on 5 August and was admitted for further examination. On 11 August, the hospital informed Peterborough that she had been treated with antibiotics. Her breast had been examined and ultrasound had shown that it was normal so she would be discharged.
50. On 14 August, the woman poured hot water and sugar on to her right leg, causing a superficial wound. She was seen by a nurse and advised to have a cold compress. She was seen by a doctor the next day after saying that she could not cope, and was admitted to healthcare.

51. An assistant clinical psychologist saw the woman as a result of her self-harm behaviour. She recorded in a detailed note in the In-reach record that the woman said voices told her to do it. She appeared distracted and said she was finding it hard to concentrate. She did not want to go back to the wing: although the other women were nice to her, she did not want to be around other people. She said that she was not taking her medication because she could not leave her cell to do so (she did not explain why not), and was not eating properly because she was afraid of “contamination”. She spoke of being a trained counsellor herself but felt that she wanted some support as she was unable to apply her skills to herself. The psychologist said that she would discuss her situation with another practitioner. She updated the In-reach record on 12 September that a visiting consultant psychiatrist had reviewed the notes and that a care plan should be devised as the endocrinologist had set out in his previous letter.
52. On 21 September, a member of staff from In-reach (signature in record unclear) met with the woman’s residential manager to discuss how staff were responding to her self-harm. They discussed:

“... acknowledging her distress, not being judgemental of her behaviour and not becoming emotionally involved by the way we spoke ... by only the necessary minimum number of staff being involved ... also to have positive reinforcements for when her behaviour is appropriate and not self destructive such as if she is able to not s/h for a period of 2hrs to be given 15 minutes of interaction with staff and if she can maintain this for 4hrs to have half hour in exercise yard with member of staff.”
53. The consultant psychiatrist saw the woman on 26 September. She told him that she had lost a baby at 26 weeks gestation after her partner beat her a year previously, and she had become psychotic. She also said she had been hearing voices for four years. He recommended the dosage of the medication which should be given to her and increased the dose of Seroquel (also known by the generic name Quetiapine, used in the treatment of schizophrenia and mania in people with bi-polar depression).
54. The assistant clinical psychologist saw the woman on 5 October at the consultant psychiatrist’s request to discuss what she hoped to gain from therapy. The woman’s clinical record describes her as being in strip conditions but it is unclear how long she had been held in this way. The psychologist wrote, “she explained that her medication has helped reduce the voices. Very eloquently explained how her pituitary gland tumour affects her metabolism and affects the effectiveness of her medication.”
55. The psychologist went on to document her discussion with the woman, which centred around her difficulties with interpersonal relationships, boundaries and her overwhelming urge to harm herself. They talked about sexual abuse, her inappropriate relationship with a therapist whilst in hospital, and her fears around intimacy and setting boundaries. The woman said she was “constantly told she is a liar and no longer feels able to identify what is real and what is not”. The psychologist told her that discussions would need to

take place within the team to determine what support she needed and whether it was available.

56. At a follow-up meeting with the psychologist on 10 October, the woman discussed her feelings of low self esteem and talked about her history of short, intensive relationships. She disclosed that she was in a relationship with another prisoner in the Healthcare Centre. A week later, she told the psychologist that, as she felt responsible for her partner's self-harm, she was unable to harm herself for fear of triggering a similar response with her partner. She went on to say that she had been warned under the Incentives and Earned Privileges Scheme (IEP) after being found by a PCO "cuddling" with her partner. (IEP is a scheme covering all prisoners which rewards and encourages good behaviour by offering incentives. There are three tiers – Basic, Standard and Enhanced. Prisoners can be downgraded if their behaviour does not meet the required standard.) Healthcare staff told the psychologist that they were engaged in a sexual act and the woman received the sanction for "inappropriate conduct".
57. The woman had further appointments with the assistant clinical psychologist on 24 October and 7 November. On 9 November 2005, the psychologist wrote to the woman to confirm the contents of their discussions: "You have disclosed a number of complex issues that you would like support in addressing. I would recommend that any such psychotherapeutic intervention be undertaken with the support of a suitably qualified mental health professional. Unfortunately, HMP Peterborough does not have access to such a professional at this time, however should it become available then we will be more than happy to refer you."
58. On 7 December, an F2052SH review took place which the woman and the psychologist attended. Concerns were expressed by a residential manager that she was writing plans for group sessions she wanted to deliver to other patients in healthcare. She was also under investigation for bullying, in that she was inciting another prisoner to harm herself. She said at the review that she had tried to drown herself four days previously and had tied a ligature around her neck the day before.
59. The woman's records do not detail significant events until 13 February 2006 when the psychologist, Nurse-Practitioner A, and the In-reach team Lead met with her to review her progress. According to the notes in the In-reach record, she appeared well presented with no visible signs of deliberate self harm and presenting herself in a "very matter-of-fact and unemotional way and quite rehearsed". She spoke of how her attitude towards child and sexual abuse had changed. She had stopped taking psychotropic drugs since December 2005 and had not experienced any symptoms of mental illness. She added that she had developed better coping mechanisms such as writing things down or talking, and she had a good supportive network as she got on well with her parents and would live with her partner in the community once released. She also spoke of a business plan to become a "corporate counsellor".

60. However, when the woman had an appointment with Nurse-Practitioner A on 10 April 2006, her attitude towards children seemed to have changed. She was unable to understand why she could not take up work involving children nor why it was wrong to have sex with a child, but then retracted this. She spoke about her father “interfering” and making complaints on her behalf, and said she “would not be there” when she was due for release but would not expand on what she meant.
61. Under the procedures known as Multi Agency Public Protection Arrangements (MAPPA) to safeguard the public and assess the risk when a serious offender is due to be released from prison, a Public Protection Panel sat on 11 May to consider the woman’s Risk Management Plan. This was necessary because she had a MAPPA level of 3, which is the highest level of risk. At the panel meeting, her behaviour was described as manipulative. The staff from her houseblock felt that she was targeting more vulnerable prisoners. The probation department reported that she had been in contact with agencies about counselling work. The education department said that, whilst their manager was off duty, she had told them she could set up a course.
62. Having served the required minimum period of a year in custody, the woman was released from prison on 1 June 2006.

### ***Recall to prison***

63. The woman’s conditional release licence was revoked on 21 July as she failed to live at an address approved by her supervising probation officer. The address was deemed unsuitable as it was close to a school. She was arrested the next day, 22 July 2006, for breaching the terms of her licence. Whilst in a cell at the police station, she made a ligature out of her socks and tied it around her neck. She was discovered by an officer during a regular cell check and, with assistance from other officers, he cut the ligature. She told him that she wanted to die because she did not want to return to prison for a year. She added that she had inserted an opened hair clip into her anus and had taken 32 Nytol tablets with alcohol the day before and was in some pain. She was taken to hospital by ambulance. Whilst appearing to be asleep, she managed to tie a ligature around her neck with material wrapped around her leg. On being told that she would require an operation, she attempted to pull the cord from a light fitting to make another ligature, and removed the cardboard from a toilet roll and pushed it into her throat to suffocate herself. She was restrained in handcuffs and taken for surgery to remove the hair clip.
64. The woman was discharged with eight types of medication on 23 July into the care of the police. Whilst at the police station she was examined by a doctor who wrote on the Detained Persons Medical Form that she would need constant observation “in view of yesterday’s behaviour”. She was taken back to HMP Peterborough later that day by the police.

## The woman's second period in Peterborough – 23 July 2006 to 25 September 2006

65. On arrival at Peterborough, the woman's health was assessed by a Nursing Sister. The Sister used a First Reception Healthscreen form which is specifically for male prisoners. This meant that she was not asked questions which related to pregnancy, although the woman told the healthcare worker that she had been raped three weeks previously. She listed the medications she was taking and the doses she had been prescribed. She said she did not have a home address and had been staying in a night shelter run by a Baptist church in Cambridge. The Sister noted that the woman was known to Peterborough's mental health In-reach Team, but the sections on the form about health-related observations on physical appearance, previous drug use or medication for mental health problems were all left blank. It is not known whether the Sister had access to the woman's records from her previous time in custody. The woman said that she had harmed herself on 21, 22 and 23 July and that she felt like hurting herself. The Sister described her behaviour and mental state as "appears rational at present but known to become unpredictable". She was referred to see a doctor the next day and for a mental health assessment.
66. From her clinical record, the woman appears to have had a secondary health screen the next day (24 July) with HCW B. The woman told her she had concerns about kidney problems and self-harm but did not want to go to healthcare. HCW B added a page to the reception healthscreen form with details of the woman's mental health medication "to be confirmed by a doctor" and her community psychiatric nurse's contact details. She referred her to see a doctor and noted that she needed more incontinence pads.
67. Under the Assessment, Care in Custody and Teamwork system (ACCT) to support and care for prisoners at risk of self-harm and suicide, an ACCT plan was opened. The woman continued to harm herself prolifically in prison. The following is a sample of entries in her ACCT plan during the first week of her return. On 27 July she cut her wrist with a razor blade. Having concealed the razor blade in a stomach wound, she began to pick at it in the morning. At 11.10am, she harmed herself by picking at her wrist wound and then told staff she had put pen refills in her stomach wound and other items up her anus. Three days later on 30 July at 8.30am, she said she had pulled the stitches out of the stomach wound. At 3.15pm, she handed a ligature to a member of staff because she could not pull it tight enough.
68. On 10 August, the woman had an appointment with the prison doctor who updated her electronic clinical record and referred her to In-reach. The doctor also referred her to a surgeon after examining a septic abdominal wound she had made by cutting herself and inserting items into it. She had her wound dressed and saw a second prison doctor on 14 August. The doctor also referred her to In-reach as she told him she was hearing voices despite taking her medication, and was feeling very muddled. On the same day, she was taken for a hospital appointment to have her abdominal wound examined. The hospital agreed to contact the prison in a few days regarding surgery.

69. The Release and Recall Section of the National Offender Management Service (NOMS) contacted Peterborough on 25 August to say that the Parole Board had reviewed the woman's case and she would be released on 25 September. The Board's decision took into account that she did not have any other convictions and that she had always attended her appointments scheduled with her probation officer. It concluded that her risk was manageable if she was supervised appropriately and that she "would benefit from the additional support of the probation service that would be afforded by a longer period on licence".
70. The woman had surgery in hospital on 25 August and was discharged three days later on 28 August. On 30 August, she took 32 paracetamol tablets and ten anti-sickness tablets. She told the Sister A the next day what she had done. Her blood was monitored and she did not need further treatment.
71. The woman's clinical record states on 11 September that she said she had been raped whilst "on leave". She appeared to have genital/urinary infections. On 13 September, she told an officer on her return from an afternoon visit that she had taken an overdose of sleeping tablets during the morning. She was taken to healthcare for observation and her blood pressure was measured. As it continued to fall and she became "less coherent and quite pale," she was taken to the local hospital but did not have any treatment. Her abdominal wound was regularly checked and the dressings changed over several days, although she was still inserting a pen, a pencil and other objects which were removed. On 17 September, Sister B recorded in the woman's clinical record that, "she was upset that she was not allowed to have medication. She told the officer that she was going to kill me and she started screaming and she ligatured at 23.00, sustained no injuries, she asked for a Listener and she settled afterwards." (Listeners are prisoners who are trained by the Samaritans to provide confidential support to their peers who may be feeling distressed.)
72. On 14 September 2006, the Public Protection Panel under MAPPa met to review the woman's Risk Management Plan. Staff on her houseblock commented that she would not be allowed to visit her partner after her release. The panel agreed to flag up to the police that, should the woman choose to target her partner's daughter, none of the prohibitions of the Sexual Offences Prevention Order (SOPO) would apply once she was over ten years old.
73. The woman was released on 25 September. An additional condition to her licence was that she should address her alcohol misuse. In order to reduce the risk to children and the public and self-harm issues, she would have weekly joint appointments with her probation officer and community mental health nurse combined with regular monthly home visits. Her risk would be monitored and reviewed every four months by her probation officer in liaison with the other agencies in contact with her. She was regarded as a high risk (level 3) offender under MAPPa. If she was to be recalled in an emergency, it should be effected within two hours.

### ***Events leading to the woman's second recall to Peterborough***

74. According to the recall consideration report written on 7 December 2006 by the woman's probation officer, the woman locked community psychiatric nurses (the number was unspecified) in her flat on 20 November. She hid the keys then tied a ligature around her neck in the bathroom, whilst blocking access to the door. Eventually, she let the nurses into the bathroom. A MAPPP meeting was held on 30 November but it was decided not to recall her to prison. First, she might not be subject to licence conditions on release and supervision by probation (because her sentence would have expired). Secondly, she would lose her living accommodation. Finally, she was "evidently unwell, although not sufficiently so as to be committed to hospital under section". However, she continued to harm herself in the community and her behaviour became more erratic.
75. On 7 December, after setting fire to her legs, the woman went to her doctor's surgery and said she felt suicidal. She was asked to report to Acute Services at hospital, which she did. She locked herself in a toilet and tied a ligature around her neck. When she was found by staff, she tried to prevent them from removing it by kicking out and punching them. She was admitted to a ward but her aggressive behaviour continued. The recall consideration report described her behaviour as extremely unpredictable. Her probation officer feared that she might return to her flat that day and try to take her life by setting fire to herself, thus endangering others who lived in the building.
76. A Senior Probation Officer endorsed the recall request. She confirmed that staff at the hospital said the woman had not been assessed as suffering from a mental illness and would not be compulsorily admitted to hospital. They also told her that she had telephoned the hospital at night, in the preceding week, and threatened to self harm. The Senior Probation Officer wrote
- "... my concern is that the woman is extremely demanding and is prepared to go to great lengths to get what she wants ... she wants to spend a lengthy period in hospital ... in my opinion the risk of her self harming has increased still further, my concern is that she will harm herself in a way that causes harm to others."
77. An Assistant Chief Officer endorsed the probation officer's report with comments that said in part:
- "... it is my view that the further deterioration in her mental health and the assault on hospital staff now raise her level of risk of harm to the level where recall is inevitable and should be on an emergency basis."
78. The woman was arrested for recall to prison at hospital at 5.30am on 8 December. She was taken to a police station. At 7.33am, she was examined by a police doctor who completed a Detained Persons Medical Form on her fitness to be detained and travel whilst taking medication.

79. The police doctor concluded that the woman:

“...suffers from mental illness. She has made numerous attempts at suicide in the past and continues to have self harm ideation. Her psychiatrist at hospital has indicated to me that in his opinion it is appropriate for DP [detained person] to return to prison”.

He assessed her risk of self harm as “high” and advised that she should be under constant observation in custody and during transport to prison. He recommended that she was fit to be detained and fit for transfer.

80. The woman was taken from the police station to the prison by Group 4 Court Services. A Group 4 court information sheet (a C15A) accompanied her. Under the section “Special Considerations” it said “DP has mental health issues. DP is on constant observations and is a high suicide risk. She has seriously self harmed and if not on constant observations, will attempt to take her own life.”

### **The woman’s third period in Peterborough – 9 December 2006 to 15 January 2007**

81. The woman was received into the reception area by Prisoner Custody Officer (PCO) A. PCO A told my investigator that the woman said on arrival that she intended to kill herself. The PCO believed that Peterborough had been pre-warned by the escorting staff about her because she was ready to open an ACCT as soon she arrived. The PCO knew her from her previous period in custody when she described her as “normally quite chirpy”. That day, however, her demeanour was “catatonic” and very different from her usual self.

82. PCO A, a trained ACCT assessor, opened an ACCT at 7.00pm. (An assessor examines what an at-risk prisoner says about their situation, suicidal thoughts and intentions, so that the level of risk can be gauged and appropriate safeguards can be arranged.) She recorded on the Concern and Keep Safe form that the woman arrived with a suicide/self-harm warning form and said she would use anything to commit suicide. The woman said she was not feeling in the right frame of mind and asked if her assessment could be done the next day. In response to my investigator’s question, PCO A said her request was not unusual as there was no point insisting on interviewing someone who was feeling unsettled.

83. SPCO A completed the Immediate Action plan in the woman’s ACCT. It recommended that she should be taken to healthcare and located in a cell monitored by a camera so that she could be observed at least four times an hour. It added that she was aware that she could use the Samaritans telephone and Listeners. However, the form was only partially completed and no arrangements were made for her to be assessed or have a case review.

84. PCO A also completed a Cell Sharing Risk Assessment (CSRA). In response to set questions, the woman told the PCO that she had not abused alcohol or

drugs nor was she dependent on them. She expressed concerns about sharing a cell and agreed that she would describe herself as a person who gets angry/frustrated quickly. The PCO assessed her risk of harm to others as being medium. (This is categorised on the form as “no immediate risk, but situation will need to be reviewed regularly.”) Section 3 of the CSRA for completion by a member of the healthcare team was signed by HCW B. HCW B did not complete the designated section based on a medical assessment but wrote in the section for concerns following a self-harm assessment: “the woman has had an ACCT book opened and I have sent her [to] healthcare for over [the] weekend.”

85. There was no documentation in the woman’s clinical record to indicate, as a new reception to Peterborough, whether she was medically screened by a healthcare worker. Neither did she have a mental health assessment. It is unclear whether she was actually placed in a camera cell, or offered the opportunity to speak with a Listener or access to a Samaritans telephone.
86. The next day (10 December 2006), the woman attempted to tie a ligature around her neck. PCO B wrote in the Record of Events that she seemed quite low and asked to be locked in her cell. The PCO explained that she could not lock the woman’s door until the scheduled lock-up time but she could lock her cell from the inside (which can be manually overridden by staff).
87. The woman asked PCO B if she could find out when a nurse would be able to change her dressing on a wound as she did not want her cell to start to smell. The PCO was told that Healthcare would make contact when the woman was required for her dressing to be changed. The PCO updated the ACCT plan at the end of the day by acknowledging that the woman  

“... has done really well today and has tried to keep herself occupied. She has written poems ... and got several books to read ... [she] has again mentioned how much she liked the wing and how friendly everyone has been towards her.”
88. Although the woman should have had an ACCT assessment within 24 hours (unless the circumstances were exceptional,) it did not take place until three days later (11 December). My investigator asked PCO A why the assessment interview did not take place within the correct time-frame, but she could not shed any light on this. She said that it was the duty operational manager’s responsibility as it was their task to obtain a log number and to put the newly-opened ACCT on the database. SPCO A said he did not know why he had not ticked the Immediate Action Plan to show that the four required tasks had been completed.
89. PCO C, a trained ACCT assessor for 17 months, interviewed the woman in the day room in healthcare at 4.50pm on 11 December. In interview, she said she did not recall reading her ACCT plan before seeing her. Nor was she aware that the ACCT had been opened three days previously. She was not

aware of any previous occasion when she assessed a prisoner more than 24 hours after the ACCT was opened.

90. PCO C told my investigators that before the assessment started the woman said to her, "I used to be just like you before I went mad." The woman said that she had been a drugs worker living a normal life until "one day her head just went and she ended up in here".
91. The woman cried throughout their session. Asked by PCO C to explain why she was feeling distressed, she said that before arriving in Peterborough, she had been "taken down to the floor" and injected whilst in hospital because of her behaviour. She believed that the injection was poisonous. She said she had no idea why she was back in prison and did not want to go back to houseblock 2 because she did not like the residential manager. She added that a residential middle manager had promised she could go to houseblock 1 or the healthcare centre.
92. The woman's parents told my Family Liaison Officer and investigator that she had felt bullied by the residential manager and had once said she would rather be dead than on his wing. They felt that, in the past, he had made life difficult for their daughter. According to them, he had made it clear that he had no time for people who harmed themselves and told her that she would not "get one over on him". They said she felt intimidated by him.
93. PCO C asked the woman about her recent acts of self-harm. She replied that she had recently had an operation to remove three items from her stomach. She said she expected to die and did not want to be alive. She said she had always harmed herself and would not stop doing it. Regarding her current mental state, she said her medication was incorrect which made her feel bad and that she had voices in her head. She said her eating pattern was fine but, if she was going to houseblock 2, she would stop eating all meals. The PCO told my investigators that the woman stated in quite a matter of fact way that she had had enough of life. She said she wanted to die and had made plans to kill herself. She said she did not have the materials to do it, although if she wanted to get them she could. She said that In-reach had refused to help her, and she had no reasons to live as she had no family and only one friend who could not visit because of the journey.
94. My investigators asked PCO C why nothing had been written in section 8 of the ACCT assessment which deals with what is going to happen after the assessment. She could not remember why and thought that a case review might have already been held before the assessment.
95. The woman's ACCT plan contained details of a case review which took place on 11 December at 4.45pm. (The first case review should be completed within 24 hours of concern being raised and is normally after the assessment.) She moved from healthcare to A1 on 11 December. A case review which should normally take place prior to discharge from Healthcare should be written on a designated ACCT case review form. It was not used in this case. Nurse B, the case manager, SPCO C and PCO C and the woman were listed

as being at the review. PCO C told my investigators that she remembered doing the assessment but did not recall being present at the review. The summary of the case review read:

“The woman is very upset as she agrees she is physically well enough to go to HBs but not mentally. She cannot understand why In-reach will not come and see her but she has refused to see them and treatment [illegible word] and will not engage with them. She claims to have made serious attempts to ligature but nursing staff [say] there are no physical marks to back this up and the “rip” in her stomach looks well healed. Has been informed she is to return to A1 which she has reluctantly accepted.”

Her risk level was ticked as “raised” and the next review scheduled for 18 December.

96. My investigators asked SPCO C about the circumstances surrounding the case review. He said that he was working in houseblock 1 and also had responsibility for the female healthcare centre as healthcare did not have a senior officer. He said he was not aware of the three day gap between the opening of the ACCT plan and the assessment. He was the duty senior officer and said that the woman’s case manager was not available at that time. SPCO C read a copy of the case review but said he could not remember anything about it. He remembered her as a “repeated self-harmer” and thought he might have known her from when he used to work at HMP Bronzefield. (There is no evidence from the records that she had been in Bronzefield.)
97. On 14 December, the woman rang her cell bell at 5.30am and asked to speak to a Listener (a prisoner trained by the Samaritans to provide confidential support to other prisoners who are feeling vulnerable). She was told that one would be on duty at 8.00am. (There is no record whether she did see a Listener or was offered use of a Samaritans telephone.) She told the member of staff (signature unclear) that she had been “cutting up” and showed her the wound. Her ACCT plan said that the cut was not bleeding badly and she did not want to see a healthcare worker. At 8.55am, she told PCO D that her grandfather had died and she wanted to go to his funeral. She also asked to speak to a Listener. The PCO advised her to make a written request to attend the funeral and she would arrange a Listener.
98. In a handwritten letter dated 14 December to the Head of Female Services the woman wrote that her grandfather had died earlier in the week. She made a “formal request” to be compassionately Released on Temporary Licence (ROTL) for three days to attend the funeral in Scotland with her mother. The last two paragraphs read:

“Since leaving H/C [healthcare] I have not s/h [self-harmed] and have behaved stably and admirably. I can give you ANY details you need to make the ROTL possible and if needs be, will leave at a time YOU suggest as long as I’m in Aberdeen by 11.30am Monday.

“PLEASE help, I’m in pieces over this but am behaving calmly and maturely. Probation will confirm I have NEVER missed an apt without reason, and I did in fact receive ROTL date before so I am seen to be trustworthy.”

Peterborough say there is no evidence to support that this letter was ever received by the Head of Female Services.

99. It is unclear whether the woman saw a Listener on that day. At 7.55pm, PCO D wrote in the ACCT plan that, although the woman had been laughing and joking all evening, she had told her that she actually felt low and wanted to cut herself. The PCO added that no Listeners had been available that afternoon.
100. The next day, PCO E wrote that the woman had been cheerful and had asked about having the frequency of her observations reduced. She said that she might feel low, however, when her grandfather’s funeral took place. On 16 December, she told the PCO that she had been refused permission to go to her grandfather’s funeral on 18 December. She said that she had written a poem which could be read out, and asked whether she would be allowed to go to the chapel on the day to light a candle.
101. My investigator could not find a record of the woman’s ROTL application or documentation giving the reasons for turning it down. The Head of Female Services was asked whether she recalled the application but she did not. She said that in any event, the Controller would have made the final decision.
102. PCO B arranged for the woman to speak with a Listener on 17 December at 11.30am. The woman thanked her and said she felt much better. The PCO wrote in the Record of Events:

“The woman has settled well on the wing and at present hasn’t self harmed. She remains very polite, although she spends a lot of time on her own, to which I have said isn’t good for her. She has been given some in-cell education to do.”

At 11.00pm, however, an entry in her ACCT plan said that the woman opened up an old wound and was feeling quite low because of her grandfather’s death. The night auxiliary officer wrote, “needs a Listener, told no because don’t have any during the night”.

103. The woman’s second ACCT case review took place on 18 December. It was attended by her, her Case Manager, SPCO D and PCO F. Her risk of self-harm was reviewed and kept at the same level (‘raised’). It is unclear whether the frequency of observations was increased. The front cover of her ACCT plan indicates that the observations were increased at some point from twice to three times an hour, but the change is undated. The summary of review described her mood as very down due to her grandfather’s funeral that day. She said that she had harmed herself the night before, but her injuries would

be looked at by a nurse when her other wounds were dressed. She asked to speak to someone relevant concerning her flat.

104. A CAREMAP (a grid of current issues concerning the prisoner on an ACCT, goals, and actions required to achieve them) was drawn up. The issues noted were that the woman did not have a solicitor and wanted legal advice concerning licence recall. She was unsure of what was happening with her partner who was in another houseblock. She had household bills that needed sorting out, and healthcare matters in that she needed incontinence pads and a medication review. The actions to be taken forward were that she required an appointment with the legal and bail unit and the unit manager would be spoken to concerning her partner (although who was to carry that action out was not identified). PCO F would contact the person who deals with housing issues. SPCO G would arrange a doctor's appointment and email the In-reach team.

105. On 22 December, the woman complained about the pain she was experiencing after putting pens in her wound. The next ACCT review date was set for 24 December and the residential middle manager would be invited to attend. However, on that date her case manager SPCO D was on duty. At 3.50pm, PCO G wrote in the ACCT plan that she had arrived back from a visit, which she said was not a good one. The entry said:

“[The woman] thinks she may ligature tonight if she can't get things out of her head. I have passed an in confidence letter to Head of Female Services for her and will try to get SO to do her review as due today.”

106. The woman was reviewed at 4.15pm by an acting case manager, SPCO H on her own. In the summary of review, she wrote:

“... stressed out as Grandad died – says that prison has been really supportive. Had a bad visit today from her mum and dad. Her dad laughed at her and said that he knew she wouldn't keep her flat. Is a bit upset about it all. Say she isn't going to self-harm as doesn't want to let her partner down. Body language positive, good eye contact.”

The woman's risk level was kept at “raised”.

107. On Christmas Day, at 5.38am, Night Auxiliary Officer A gave the woman a surgical dressing for a “superficial cut”. She went to church and spent most of the time speaking with her partner. There were no concerns about her. A further ACCT review took place on 27 December with SPCO G, PCO I and the woman (who was described as very talkative throughout). She said she was still harming herself but not as often. The summary of the review said that she was settled on A1 and was mixing well. She was seeing her partner on occasions:

“[This] gives her support. Needs her medication reviewing by healthcare and to see in-reach. Good eye contact and body language. Conversations – 4 per hour, observations 2 per hour.”

The CAREMAP was updated and her risk was downgraded to “low”.

***Adjudication hearing – 30 December 2006***

108. On 30 December at 7.05am, the woman was issued with a Notice of Report (F1127B) under the prison disciplinary system. This said that she had been placed on report by PCO J for having an unauthorised article, contrary to Prison Rule 51 paragraph 12A. The report of the alleged offence said that medication wrapped in paper inside a hot water flask had been found during a search of her cell (A1-10) on 29 December at 4.10pm.
109. The Controller opened an adjudication later that day. Using a Record of Adjudication Hearing, which sets out the process which should be followed, He asked the woman to confirm that she had received the Notice of Report and that she understood the procedure. He noted her responses. She said that she understood the charge and had not made a written reply. She had had enough time to think about what she wanted to say. She did not wish to call witnesses or need any assistance. She pleaded guilty to the charge. She did not have any previous findings of guilt on adjudication. As PCO J (the reporting officer) was not present, his evidence was read out by SPCO I. Asked whether she understood the evidence, agreed with it and had questions for the reporting officer, she replied “yes” to all three questions. The Controller adjourned the hearing until the reporting officer was able to attend.
110. On 31 December, the woman complained of a swollen stomach and an infected leg. She was found in her cell doubled up in pain the next day. She was taken to hospital for an operation and returned to the prison on 2 January 2007 after having a catheter fitted.
111. The woman’s parents told my Family Liaison Officer and investigator that the hospital had told the prison that she would require a stand for the catheter and offered to provide one. According to her parents, Peterborough had assured them that the appropriate equipment was in place. However, the stand did not materialise and she had to tape a long piece of tubing to her leg. This made it difficult for her to negotiate flights of stairs or get to the visits room. However, her parents said that visits staff did their best to make her situation more comfortable.
112. The woman’s fourth ACCT review took place on 3 January. SPCO H, PCO J and the woman all attended. She was very talkative and seemed positive. She said that her wing was settled and she wanted to stay there. Her housing and medication questions had been resolved, but she was concerned that her supply of incontinence pads would not be sorted out. Her risk level remained as “low” and the next ACCT review was scheduled for 12 January. Her parents told my Family Liaison Officer they had taken incontinence pads to Peterborough when she was experiencing difficulties getting a regular supply. However, on more than one occasion, Peterborough had refused to accept

them. The situation had been resolved eventually when a senior manager intervened and arrangements were made for her mother to take the pads in.

113. The woman was moved to D2 unit on houseblock 2 on 5 January. No reason is given in the ACCT plan. She told PCO K that she did not like it and wanted to be placed on report for refusing to go. After a chat, she said she would go but would not be there for long. On arrival, she told PCO L that she did not want to be there and would do anything to go to healthcare or the separation and care unit. The rest of the morning passed uneventfully and she attended a writing group in the afternoon.
114. On 7 January, she pushed a note under her door which was found by a night auxiliary officer at 1.45am. The note said she was going to kill herself on Friday (12 January 2007). There is no indication of whether any actions were taken as a result. The woman told PCO L and PCO M that she felt upset because her partner was being moved to another prison. She asked to contact the chaplain and told PCO N that her blessing with her partner was supposed to have taken place but had not. She wanted the PCO to pass some poetry to her partner but was told that letters could not be passed between prisoners. The PCO suggested instead that she should post it to Holloway (the prison her partner was going to). The on-going record in her ACCT plan showed that she was not happy but agreed to do so. An entry in the ACCT by a night auxiliary officer at 9.10pm described her lying on the floor (of her cell), "with right foot propped up on shelving, called her name but no response – breathing observed – will keep a close eye on her". She was next checked at 3.15am and again at 6.15am.
115. At 9.30am on 10 January, PCO O wrote in the ACCT plan

"... we had a brief chat regarding her catheter and getting someone over to remove it as she is in agony unless she continually drains it. She also mentioned how she is feeling guilty with certain issues relating to her partner and feels the easy way out would be to kill herself."

At 4.50pm, her wound was re-dressed and the catheter removed. At 9.32pm, she asked the night auxiliary officer to pass on her "best wishes and good luck" to her partner.

116. At 3.30am on 11 January, the woman asked if her partner was asleep as she was worried that she might be worrying about her impending move to Holloway later in the day. She spent much of the night awake. She was told that her partner was fine. At 7.30am, PCO L wrote in the ACCT plan that she said goodbye before her partner left. She spent all morning crying and was very upset. She saw a general practitioner. His note of their appointment read

"... wants counselling to stop self harming, in-reach will no longer see her, continuous litany of complaints, she has full understanding of problem, is on adequate meds."

117. A MAPPA Public Protection Panel met on 11 January. An unidentified PCO from the woman's residential houseblock commented:
- “... there are issues with her bullying staff if she doesn't get her own way and if staff do what she asks, she constantly writes to them, which could lead to grooming. Has an open ACCT but there isn't much self-harm at the moment. Was recently turned down to go to her grandfather's funeral, there was no reaction.”
118. On 12 January, Night Auxiliary Officer B noted in the woman's ACCT plan at 6.20am that she “has been quiet and settled all night. Slept soundly.” PCO P checked her at 11.30am and saw her watching television and writing a letter. The PCO noticed a few blood stains on her pillow but she did not want to talk about them.
119. The woman had a legal visit in the afternoon from a solicitor. (My investigator attempted to make contact with him but he no longer works at the firm and could not be traced.)

***Resumed adjudication hearing – 12 January 2007***

120. The Deputy Controller conducted the woman's reconvened adjudication hearing. She confirmed, as before, that she understood the process, did not wish to call any witnesses or need any assistance. She admitted the charge. The reporting officer, PCO J, was present and read out his evidence. The Deputy Controller asked her whether she wished to ask him any questions. She first said she did not but then asked him to divulge what type of medication it was and why it was being secreted. The reporting officer replied that she had ten paracetamol tablets which she wanted to use to harm herself as she was in a very low mood at the time. The woman said that she had collected the tablets at the medicine hatch, hidden them in her cheek and was collecting sufficient to be able to kill herself. She told the Deputy Controller that she had been in hospital and had been recalled to prison. She gave the names of the clinicians responsible for her care.
121. The woman went on to say that her grandfather had died and she had wanted to attend the funeral in order to support her grandmother but had not been allowed to do so. She said that, after she had been given that decision, she decided to store up medication in order to kill herself. She told the Deputy Controller about her sessions with the Assistant Psychologist who had told her that her problems were “too deep and disturbing” for her to treat and that she should be referred to an external psychologist. She said that her self-harm was bad and she had tried to cut her breast off the previous night.
122. The Deputy Controller asked the reporting officer whether he wished to comment on what had just been said. He replied that much of what the woman had said was true and it was very frustrating for officers to see what she was going through. He said, “we try to get her help and all we are told is

that healthcare cannot help her and that she is on her medication and that is all they can do.”

123. The hearing was adjourned for the second time for healthcare and In-reach reports to confirm whether what the woman had said was accurate or otherwise. After the account of the hearing, the Deputy Controller wrote:

“N.B 12/1/07. Written report re-this matter produced and circulated by JJ to Director, Head of F Res, Head of H/C & Head of In-reach Team and Duty Manager to make everyone aware of information divulged by PR during adjudication.”

124. The Deputy Controller sent a memorandum dated 12 January to the Head of Female Prison Services, Head of Healthcare and Head of In-reach Team. Headed “Urgent action required” she wrote:

“I am writing concerning the above prisoner and enclose some detailed observations that require a number of actions as you deem fit. Due to the serious nature of the information divulged during the adjudication [charge F8132/06] today I have quickly put this in writing to you.”

125. Attached was a summary document giving some of the information that had been said during the hearing. The Deputy Controller asked for confirmation of the medication the woman had been prescribed, what dates she had been given paracetamol and raised a query about whether there was a protocol for soluble medication. She quoted the relevant paragraph of Prison Service Order 2000 on adjudications which states:

“Disciplinary charges should not normally be brought either in respect of deliberate self-harm or of preparations for this. The Prison Service’s response to self-harm or attempted self-harm must look to the care of the individual prisoner as its priority. If early signs of a tendency to self-harm are overlooked or met with a punitive response, the risk of eventual tragedy may be increased.”

126. The Deputy Controller raised several points in a section of her summary document addressed to all Female Residential Managers. She said that, while the matter would be investigated and she would wait for healthcare feedback before making a final decision, the charge might be dismissed because it was deliberate self-harm. She added that the woman had “some prior history” and speculated that she might be trying to manipulate the adjudication process. On the other hand, she acknowledged in the woman’s defence that her recent bereavement had been confirmed and she had said she began to secrete the tablets after being denied permission to attend the funeral.

127. The Deputy Controller ended the document:

“I am documenting these matters in order that the woman’s intention is recorded and steps can be taken as the Contractor feels appropriate as

regards her threatened self harm. I would also wish to make the Contractor aware of possible ramifications should the adjudication be dismissed for reasons of self harm.”

128. In addition, the documents were emailed to Head of Female Services and to the Controller at 4.59pm with a covering note which said:

“I have circulated the attached information via today’s Duty Manager but enclose an electronic copy for your information. I have already discussed this briefly with the residential middle manager today.”

129. An entry in the woman’s ACCT plan by PCO O highlighted the concerns expressed by the Deputy Controller at the adjudication. She showed the PCO cuts to her left breast. She said she wanted to cut her breasts off because she hated them.

130. At interview with my investigators, the Deputy Controller said that she spoke to the Offender Interventions Manager by telephone. At her request she left enveloped copies of the memorandum in the manager’s pigeon hole with an instruction specifying urgent delivery. Before she left the prison that day for the weekend, she handed a copy of her memorandum to the Director and briefed him on its contents. She told the investigators that the woman had been quite composed when explaining her reasons for wanting to take her life. The adjudication was memorable:

“... because I have experienced on a lot of occasions people exhibiting self-harm but I’ve never come across somebody that says they’ve wanted to cut off their breast. To me, that’s an extremely serious matter and gave me an indication of her state of mind which I was very concerned about.”

131. Asked about the role of a Controller as adjudicator, she said that she could “strongly advise” staff but could not dictate what should be done in relation to what she had heard at the woman’s adjudication. Nevertheless, as there did not appear to be a pathway in the women’s prison (unlike the men’s prison) for highlighting issues that arise from adjudications, she decided that she had a duty of care to make the relevant people aware of what she had encountered. She did so because she was not in charge of the officers attending the hearing. She could not be sure of their custodial experience or whether they would take responsibility for ensuring that the concerns would be flagged up. In response to this, the Director of Peterborough said ‘There is no pathway on the male side. The procedure for both sides is the same. If the adjudicator has any concerns over any issue they raise it with the SCU SPCO [Safer Custody Unit Senior Prisons Custody Officer]’.

132. The Offender Interventions Manager emailed the Deputy Controller at 7.02pm to confirm that the woman was on an open ACCT plan. She had spoken to SPCO B, Safer Custody Manager, who had undertaken to note the Deputy Controller’s concerns in the woman’s ACCT plan, check that she was being observed appropriately and carry out an interim case review. Self-harm

markers had also been put on the computerised systems LIDS and IMS, which are used to hold prisoner data.

133. SPCO B conducted an ACCT case review at 7.15pm with the woman. No other members of staff were present. Although the previous case review had earmarked the next one for 12 January, it appears that no arrangements had been made to ensure that it took place. The case review had been prompted by the Deputy Controller's concerns. At interview, SPCO B told my investigators that the Offender Interventions Manager contacted her to relay the Deputy Controller's concerns about the earlier adjudication. SPCO B said she spoke to the woman for quite a while and asked her to hand over anything that she might be thinking of using to harm herself. She said she did not have anything and talked mostly about her partner and her partner's daughter who she thought of like her own daughter. She did not talk about her reasons for planning to take an overdose. After she was locked in for the night, she called the SPCO to her cell and handed over a razor. She said this was because she felt the conversation had helped her and she wanted to show her appreciation.
134. The summary of the review said in part that the woman seemed "stressed at the moment. Obs to remain the same." SPCO B explained to my investigators that she increased the risk level to "raised" but did not increase the frequency of observation from twice an hour because the woman seemed more relaxed and happier after they talked. The woman said she had been moved from houseblock 1, where she felt settled, to a wing where she did not know anyone and had no support. She had handed over her razor and asked the SPCO to come and speak to her the next day. The SPCO thought that they had reached a level of openness to the point that the woman would have given her any concealed medication.
135. Asked whether the Offender Interventions Manager's request to conduct a case review on the woman seemed out of the ordinary, SPCO B said that it did not appear distinctive. She explained:
- "When the Controllers used to do the adjudications, you used to get quite a lot of that sort of thing ... especially if they'd been awarded something or you know, a punishment of any kind but somehow it didn't surprise me."
136. PCO L wrote in the woman's ACCT plan at 7.20pm:
- "The woman (sic) is upset about Tuesday saying she jumped off the top of the toilet onto the floor and no one made sure she was okay. She has stated she does not like this wing and the girls have all got big mouths."
137. At 9.01pm, SPCO B emailed the Offender Interventions Manager and the Deputy Controller saying she had spoken to the woman:
- "We had a very long chat and she did say she felt a lot better now that she had been able to off-load but she still would not hand over

anything. She is troubled and spent most of the time talking about her partner and also talking about her daughter (not biological). I have told her I will see her again over the weekend for another chat and this seemed to put her mind at rest. I feel this is going to be a long road.”

138. The following day, SPCO B returned to the woman’s cell to see her as promised. She was in bed with a duvet pulled up high and a blank look on her face. The SPCO pulled back the duvet which revealed that she had tied a ligature around her neck. She left the cell and returned with a ligature-cutting tool and another PCO. She told my investigators that the woman’s face was discoloured but the ligature was not tight. She appeared a bit embarrassed and asked her to close the cell door. She had fashioned the ligature from the metal wire in her bra with fabric wrapped around it, but finally they managed to cut it off. (The ligature-cutting device could not cut through the wire so the fabric had to be stripped away and the wire pulled out.)
139. SPCO B asked whether the woman wanted to talk to her. She nodded so the PCO was told that he could leave. The two women talked for about an hour and a half. She admitted that she found it difficult to ask someone to talk with her so she would tie the ligatures in order for someone to cut them off, knowing that they would then talk to her. She confessed that she thought the SPCO had lied when she promised to return to see her. She said she had changed her mind about wanting to move back downstairs as she wanted the SPCO to be her case manager. She said the SPCO had had an honest relationship with her partner when she was her case manager, and she was hoping that their relationship could be the same.
140. My investigators asked SPCO B, as the Safer Custody Manager, about the frequency of finding ligatures at Peterborough. She explained that it was an everyday occurrence, so finding the woman’s under her duvet with one tied around her neck was not unusual. There were prisoners who would have several ligatures removed in a day. She spoke of a prisoner who had tied seven ligatures around her neck in one morning before lunch time. The only aspect that was out of the ordinary was that the core of the ligature was fashioned out of wire. The SPCO said she did not ask the woman about the technique lest she regarded it as special and took encouragement from her question to try it again.
141. On 13 January, Sister C cleaned and dressed the woman’s abdominal wounds. At 6.26pm, she updated the clinical record to record that the woman had tied a ligature around her neck at about 2.55pm but there did not appear to be visible evidence of injury and no treatment was needed. On examination at 6.20pm, Sister C saw that she had made cuts on her left breast of approximately three inch diameter around her nipple. The cuts were no longer bleeding but, although they looked as though they needed covering with steri-strips, she refused treatment.
142. PCO O wrote in the woman’s Record of Events:

“The woman has had a difficult week due to her partner being transferred to Holloway. She tends to stay in her cell and keep to herself. She does not like D2, she says it is too loud and she doesn’t like the other prisoners. There have been some self harm issues over the last few days and she has told officers that she cannot cope and wants to die. Is polite and respectful to staff.”

(This is the last entry in her history sheet.)

143. On 14 January at 6.30am, Night Auxiliary Officer B wrote in the woman’s ACCT plan that she had slept all night and there were no problems. Two hours later, PCO O noticed fresh blood on her bedding. Later in the morning, she asked her about her self harm. She said that she had re-opened a wound but fell asleep before she could “go too far”. She seemed quite talkative and said she felt better after a conversation. While she was watching television she said that seeing others who were worse off than her made her “put things in perspective and feel better”. She said she wanted to clean her cell and asked PCO O whether she could have clean sheets as she did not feel like harming herself and they would remain fresh. She spent the afternoon writing and watching television. PCO N wrote in her ACCT plan that she shared a joke with officers after receiving a healthcare appointment slip addressed to “the man”. Her mood was described as good and she was smiling a lot.

#### **Events on 15 January**

144. On 15 January 2007, Night Auxiliary Officer B wrote in the woman’s ACCT plan at 6.20am that she had woken up early and was half-sitting in bed, hiding something under her duvet. She did not respond to him. At 8.55am, she was still in bed although she told PCO P that she was going to get up in time for her housing appointment. By 11.00am, however, she told the PCO that she would not attend as she was feeling low from over the weekend and had scratched at her cuts.
145. In an untimed entry, PCO L wrote that the woman was depressed and sleeping more during the day so she could not make ligatures. She said she did not want to die. She had made good friends with Prisoner A but was missing her partner and did not like the girls on the wing as “some are loud and rude”.
146. PCO L told my investigators that the woman had hated houseblock 2 when she first arrived as she disliked the residential manager because he would not let her go to houseblock 1. The PCO could not see why she did not want to stay as her partner was also on houseblock 2 but in a different wing. She did not like PCO L at first and it was only shortly before her death that they began to get on. The PCO said the woman would tie ligatures around her neck but, if she felt she had gone too far or they were too tight, she would press her cell bell and ask a member of staff to cut them off. The PCO described tying ligatures as a coping mechanism which made prisoners feel better while they were being strangled - but it was a release when the ligature was taken off. She had removed many ligatures from women.

147. During the evening on 15 January, the woman asked PCO L to photocopy a blessing for her so that her partner could have a copy. The PCO thought that she seemed in fine spirits and had filled out her canteen request form to buy goods from the prison shop. The PCO with PCO N carried out a roll call check of prisoners, which is a visual inspection to make sure that they are in the correct cells. PCO L handed over the wing to Night Auxiliary Officer B at about 8.15pm, checking that the doors were locked. She told him the woman was the only prisoner on D2 with an ACCT but that she had been in good spirits that evening.
148. The last entry in the woman's ACCT plan said, "on checking doors, she looked at me, seemed to be writing a letter. Has been asleep on bed since." It gave the time as 8.15pm but was unsigned and undated.

### **Discovery of the woman's death**

149. After PCO L handed over duty for the night to Night Auxiliary Officer B, they went to the hub, a central office area with access to all wings which are arranged in a radial pattern. The houseblock supervisor told the police that he discussed the day's events on the houseblock with Night Auxiliary Officer B at about 8.30pm in the hub. All the open ACCT plans were laid out in wing and cell numerical order. PCOs who were finishing their evening duties on A2, B2, C2 and E2 performed a similar handover, eventually leaving Night Auxiliary Officer B in charge of 170 prisoners in the houseblock, eight of whom had open ACCT plans. The woman's was the only ACCT plan on D wing. The front cover of the plan gave the frequency of observation as three times per hour (although the case reviews since 27 December had reduced this to twice an hour).
150. Night Auxiliary Officer B was interviewed by the police under caution on five occasions over three months. He initially told them that, after he took over duty, he looked in cell D2-10 and saw the woman in bed under her duvet. She appeared to be reading under the covers or "doing something". He said that he continued his duties on the wing. He remembered seeing the light on in her cell and heard her moving about inside. At some later point (although he was unable to recall the time), he noticed her cell light was off.
151. Night Auxiliary Officer B said that at about 11.00pm he started to check all the cells in houseblock 2 and came to D wing. He looked into the woman's cell through the observation hatch and saw her lying on the floor next to the bed. He could see that she was not breathing but could not see if there was a ligature around her neck. He called for a medical response team on his radio, took their keys as they arrived (which he said was standard procedure) and left the wing. As he left, he heard a nurse calling her name. A short while later, an ambulance arrived.
152. SPCO J and PCO Q were part of the four-person quick response team that would deal with any incidents in the prison during the night. They heard Night Auxiliary Officer B request medical assistance over the radio. They ran to D2,

arriving three minutes after the request was made. PCO R collected Nurse C from the healthcare centre as she did not carry keys and could not move independently. An Orderly Officer also made his way to D2. They arrived a minute later.

153. Nurse C told the police that she went into the woman's cell and saw her lying on her back with her feet near the door and her head under the window:

“Her head was leaning slightly to the right. I saw she was blue in colour and she was not breathing. I saw a ligature wrapped very tightly around her neck, I think it was wrapped twice and was quite thick. PCO Q removed the ligature but had some difficulty doing so due to the tightness. I began calling her name and moving her to see if I could get a response. I saw her eyes fixed, her face was blue and so was her tongue. I began CPR [cardio pulmonary resuscitation] with constant assessments. I kept giving her breaths whilst the PCOs gave compressions. I used my ambi-bag and resus mask but could get no response. We continued CPR with attempts to use the de-fib machine but could get no response. We continued until the ambulance crew arrived at about 23.15 hours, they then took over and I assisted them with CPR until they said to stop. We just covered her over and were told to leave the cell.”

154. Nurse C told police that she did not have keys when the alarm was raised so she had to wait for a member of the response team to open doors. The ligature round the woman's neck was not attached to anything. Once it was removed, she assessed her condition but there was no response. The nurse continued breathing into her body whilst the Orderly Officer carried out chest compressions.

155. PCO S told police that he was telephoned at about 11.30pm to ask him to cover Night Auxiliary Officer B's duties. On arrival, the PCO said he went to houseblock 2 and saw the auxiliary officer walking around outside in what appeared to be a daze. Night Auxiliary Officer B said “something along the lines of ‘I think I've fucked up here’ but when asked why, did not reply”. The PCO took him away to have a cigarette. Night Auxiliary Officer B did not speak and sat with his head in his hands. The PCO checked the wing to account for the other prisoners and then checked all the ACCT books to see what needed to be done. He said that no night paperwork had been completed so he started from scratch.

156. Once the necessary administrative procedures following the woman's death were completed, a hot debrief, chaired by the Director, was held at 5.35am on 16 January. (The purpose of a hot debrief is to bring together all staff who have been involved in the immediate aftermath of a serious event. In this case, it enabled them to discuss the immediate response to her death and any issues that had arisen.) In a summary note of what was discussed at the hot debrief, a member of staff (the summary did not indicate whom) suggested that her body had been cool to the touch and her lips grey, suggesting it was possible she had been dead for a while.

157. Closed circuit television (CCTV) coverage of houseblock 2 did not support Night Auxiliary Officer B's version of events. It is possible that the CCTV system may have been set at 10 - 15 minutes slower than Greenwich Mean Time. There was no sighting of him patrolling the wings between 8.36pm and 9.08pm. In addition, it was not possible to see whether a cell light was on unless one lay at floor level or looked through the cell observation hatch. The CCTV evidence shows that he walked past the woman's cell five times between 9.08pm and 9.38pm without looking inside. There were no sightings of him on CCTV from then until 10.42pm. The CCTV shows him checking the cell at 10.45pm. He then kicked the door and waited for assistance.
158. Night Auxiliary Officer B subsequently admitted to the police that he got a television to watch "to pass the time" and walked past the woman's cell a few times. He said he had seen her light go on and off a few times. He admitted to "forgetting" to do the 10.30pm roll count as it came around quicker than he thought, so he just gave in the figures he had counted earlier. He started to do checks on ACCT prisoners at 11.00pm. He said he did not know there was a specific requirement to check every cell and he did not have formal ACCT training. He had shadowed one night duty and a week of day shifts. He said he did not like doing nights on houseblocks but his requests to be moved were ignored. ACCT and night shifts caused him stress. He had written to the Human Resources Department saying that it was affecting his home life but his letters were ignored. He said he was not comfortable dealing one-to-one with prisoners. He said he had not been given specific instructions on what to do when checking ACCT prisoners, and thought the ACCT book observation times were a recommendation rather than something mandatory to complete. He admitted that he had not read the woman's ACCT plan thoroughly. He said he wrote the last entry in her ACCT because he had been told to write something about a handover, but he was feeling "panicky" when he did so.
159. Night Auxiliary Officer B was asked about the CCTV records but could not explain his movements. He said he had made various requests of the prison which had been ignored, so had decided to come in and do his job but do nothing more above the call of duty. He felt used by the prison and "didn't see why he should do anything extra for them, when they haven't done anything for him". Regarding the documentation about night ACCT checks, he said he sometimes just ticked the boxes at the end of a night and may or may not have made the checks. He was not aware that the woman had a ligature removed from her neck on 13 January even though it was written in the ACCT plan. He told the police he had never been told to read an ACCT plan; he would just use the information given during the handover. Asked if he felt he had let her down, he replied that he felt he should not have been there in the first place without the correct training. He felt the prison was responsible for her death and he would never come to terms with what had happened.

### **Peterborough's liaison with the woman's family**

160. The woman's parents were told of their daughter's death at around 4.15am on 16 January by two police officers from Norfolk Constabulary who visited their home. Unfortunately, the officers had very little information and could not provide any details of what had happened to her. The officers left contact telephone numbers for Peterborough's Director and for HM Coroner. They said that a liaison officer from the prison would contact them shortly. While her parents were waiting for the liaison officer to telephone, they were deeply distressed to find details of what had happened to her on Teletext ahead of being given any information by the prison. The liaison officer did make contact but, after the initial conversation, the family felt they were left to pursue the prison for any information.
161. A memorial service for the woman was held at Peterborough a few weeks after her death. Her family attended and were able to meet staff and friends that she had made during her time in prison.

### **Further perspectives on the woman from friends and prison staff**

162. At interview with the police, the woman's partner said that she had known the woman as a friend since 2004 (before she had been taken into custody) and they had started a relationship in August 2005. The woman had talked to her about self-harm and alleged sexual abuse and she had no reason to believe that she had said things which were untrue. Their relationship had divided staff at Peterborough, some of whom thought it made them harm themselves more whilst others helped them write out a blessing service they wanted to have. The partner said the woman had been depressed by the lack of care she experienced at Peterborough such as not receiving mail, medication, incontinence pads, or having her catheter changed. These difficulties had made her harm herself and she complained that the ACCT plan staff checks did not happen. The partner added that dispensing medication was lax and both she and the woman used to stockpile tablets to take when they felt like it. On one occasion, the partner had been worried that the woman would take an overdose and kill herself so she had told two PCOs. Her cell was searched and the tablets were confiscated.
163. Prisoner B who knew the woman when she was at Peterborough, had warm memories of her. She described her as unusual, very caring, intelligent and special. She said that she had helped support other prisoners with mental health and/or self-harm problems. She talked with one prisoner, Prisoner C, in particular. She encouraged Prisoner C to clean her room, keep herself tidy and spend her money in the prison shop wisely. She would also write letters to relevant departments on the woman's behalf. Prisoner B said that when the woman was in Peterborough in 2005 and 2006, she (and others including herself) had been a victim of a form of bullying which was not physical. Unpleasant songs were sung about her through cell windows or air vents which the women used to communicate through. Eventually the bullying stopped when the women concerned were moved to other prisons in early

2007. She said that she was horrified by the woman's death and expressed her sympathy for the woman's parents.

164. A middle manager at Peterborough described the woman as a very intelligent woman who engaged in prolific self-harm. He said that she would try and manipulate situations. She would ask staff if she could help other prisoners who would harm themselves. She had problems of her own so she was not allowed to help. She liked writing, she liked attention and she was approachable. Nevertheless, she harmed herself a lot and once said that she liked the "sting" of cutting herself. She would tie ligatures around her neck quite frequently. He recalled one occasion when four prisoners in adjacent cells all tied ligatures as a plan to get a response from staff. That day was particularly stressful for the staff concerned. He felt that she knew the consequences of what she was doing and might have liked the drama of it. He said that he sincerely doubted whether any more could have been done for her, but there had been dramatic improvements since her death in the safer custody work. Staff were passionate about trying new ways to keep prisoners safe.
165. The residential manager who used to work at Peterborough but had left in 2008, spoke to one of my investigators about the woman. He said that, as far as he could recall, she had a lot of issues as a person that she could not express. He did not describe his relationship with her as good. She would not speak to him because he had to talk to her about her poor behaviour when she sent an inappropriate letter to a member of staff. He maintained that she was not regarded unfavourably because of her self-harm and that she was "cared for according to the proper protocols". My investigator spoke to him about her family's concerns that he bullied her. He denied doing so and said that his door was always open to her but she did not get on with him. He said that his relationship with her was as good as she would allow.
166. As for her family's concerns that the residential manager had blocked the woman's access to jobs, he said that he had not been involved with the prison labour allocation board. He thought that her difficulty securing work might have been due to security considerations and self-harming issues.
167. The woman's family told my family liaison officer that the Head of Female Services treated their concerns with indifference. My investigator raised their concerns with the Head. She said it was possible that the woman's father did raise the issue of missing post with her but she could not recall this. She did not remember having any contact with the family other than one meeting before the woman was recalled for the second time. It was attended by the father, herself, and the then Head of Healthcare. She described the father as irate and said the meeting ended after 30-40 minutes because it did not appear to be leading anywhere. My investigator also made efforts to contact the then Head of Healthcare, who was reported to have left Peterborough. I have since been informed that she left the PCT to work for the prison, but I was unaware of this at the time of my investigation.

## **Post mortem and toxicology reports**

168. The post mortem examination was carried out on 18 January 2007. The report said that the cause of death was asphyxia consistent with soft ligature pressure of the neck. Toxicology tests were carried out on samples taken from the woman's blood, urine and gastric contents by a Consultant in Clinical Chemistry at Sheffield Teaching Hospitals NHS Foundation Trust. The tests revealed that the body contained three substances of note. There was a high amount of Tramadol, an analgesic (pain relief) tablet. In the toxicology report, he commented:

“... the Tramadol is at a concentration that is potentially fatal. The low metabolite concentration may imply a recent acute ingestion. The Diazepam and Mirtazapine are likely to represent therapeutic range use.”

169. In the light of the findings, the pathologist issued an addendum which concluded that:

“... it seems inherently unlikely that Tramadol intoxication directly contributed to death. However, I cannot exclude the possibility that it made death more rapid in circumstances of ligature compression of the neck. Perhaps more relevant to the circumstances of the death, the finding of a level of Tramadol likely to reflect excessive consumption over and above normal therapeutic administration, probably reflects deliberate relative overdose in the period leading up to ligature compression of the neck. Such overdose may have been possible due to hoarding of prescribed and administered medication.”

## **Conduct of Night Auxiliary Officer B**

170. Night Auxiliary Officer B was suspended from duty on 2 February 2007 and later resigned his post. The material gathered by Cambridgeshire Police was presented to the Crown Prosecution Service (CPS) for consideration. In a letter to the man's parents a lawyer with the Special Crime Division said he had considered the offences of gross negligence manslaughter and misconduct in public office. In deciding whether there was a realistic prospect of a conviction on the grounds of gross negligence manslaughter, he explained that the law required four aspects to be proved: that there was a duty of care owed by the defendant to the victim, there was a breach of the duty of care by an act (or omission), that the death was caused by the breach of the duty of care, and that the breach should be characterised as gross negligence and therefore as a crime. The lawyer wrote, “The Court of Appeal described the relevant criminal conduct as justifying the description ‘reprehensible’.”

171. The lawyer said that before the criminal charge of misconduct was made, there had to be a serious departure from proper standards. He went on:

“Night Auxiliary Officer B breached his duty of care to the woman.

“... Unless one can show a breach which did more than minimally contribute to her death then a critical link in the chain of causation is not established. The difficulty with causation ... is the time it took her to die ... even if the inspections were being carried out every 15 minutes in accordance with the ACCT book, could have meant she was beyond the point of return within a few minutes of applying the ligature. Therefore it is impossible to say, to the criminal standard, that the breach of duty in checking her was a more than minimal contribution to the cause of death ... Although she tried to take her own life two days previously, I am not satisfied that a jury would decide that the breach by the officer was so bad as to be a criminal offence ... the officer is a public officer who has wilfully neglected to perform his duty without reasonable excuse or justification ... However, measuring the misconduct against previous case law I was not satisfied that a jury would consider the omission of not carrying out checks over two and a half hours to be such an abuse of the position that falls so far below the required standard, even in the case where she was able to take her own life. In the light of that conclusion there is insufficient evidence upon which to base a realistic prospect of conviction for an offence of misconduct in public office.”

## CLINICAL CARE

172. An independent clinical review into the healthcare the woman received whilst at Peterborough was commissioned through the Strategic Health Authority. The Care Services Improvement Partnership (CSIP) Health and Social Care in Criminal Justice programme contracted a Lead Reviewer, a Specialist Mental Health Reviewer and a Consultant Forensic Psychiatrist to carry out the task. (Due to changes in the commissioning arrangements, re-organisation issues and inevitable changes in personnel at Peterborough since 2007, the clinical reviewers were unable to contact all those who played a part in the woman's care.)
173. The clinical review of the woman's healthcare has exposed significant shortcomings in the provision of healthcare services at Peterborough. The review says it was a prison struggling to provide a decent healthcare service to those it was holding. Whilst many staff were no doubt committed, there were major problems, seeds of which had been sown before it opened. Unlike most contracted-out prisons, Peterborough's healthcare services were provided by PCT rather than in-house. Although this was an innovative approach, the review says it is doubtful whether the contract drawn up before the prison came into existence actually met the needs of the population it was meant to serve. Healthcare should have been equivalent to that received in the community and action should have been taken sooner to remedy this.
174. I support all the clinical reviewer's recommendations.

### Primary care services

175. When the woman was first recalled to Peterborough in July 2006, her First Reception Healthscreen was recorded on a form that explicitly said it was for male prisoners. There are separate healthcare centres at Peterborough for male and female prisoners, and it is very disappointing that the wrong forms ended up in female healthcare.

**I recommend that the Director satisfies himself that all first reception healthscreens are conducted on the appropriate forms.**

176. The woman's clinical record did not indicate that she received a reception healthscreen when she returned to Peterborough for a third time in December 2006. No matter how familiar staff may be with a prisoner who has been to the establishment before, it is essential that all newly-arrived prisoners undergo the screening process to update the prison on their current health and circumstances.

**I recommend that all recalled prisoners have a First Reception healthscreen.**

177. The clinical review has also found that healthcare procedures concerning the woman's reception on 8 December 2006 were inadequate:

“Although on previous admissions she was assessed on her arrival, there was no record in the documentation that this happened on her admission to HMP Peterborough on 8 December 2006. An entry in the continuous medical record dated 14 December 2006 suggests a secondary health screening was undertaken. There is no assessment of her mental health needs or risk associated with self harm. No reference is made to her CPA status and no referral was made to the mental health in-reach team. It was not clear how individuals were trained to undertake reception health screening, or what measures were in place to audit the quality of the process.”

178. In relation to the availability of mental health resources, the review is critical:

“There is a high prevalence of minor psychiatric disorders amongst female prisoners. Despite this, there appears to have been little provision made for a primary mental health service at HMP Peterborough. There was limited involvement from General Practitioners in prescribing and reviewing medication for those with anxiety and depression. No protocols were available to clarify the role of a primary mental health service or how this interfaced with the mental health in reach service. Mental health nurses had been employed within the primary care team but retention had been poor as pressure of other duties meant they could not concentrate on a primary mental health role. The lack of a significant primary mental health service resulted in increased pressure on the limited resources of the mental health in-reach team ... it was not clear how communication occurred between the primary care team and the mental health in-reach team. The teams were not co-located. The joint weekly allocation and discussion meeting identified in the mental health in-reach operational policy (2005) did not take place due to time restraints.”

179. Other findings of the clinical review include:

“There was no evidence in any of the documentation of a structured approach to care planning which may have helped to address the needs of the woman in relation to her physical health. She appears to have experienced a number of difficulties spanning her three admissions to HMP Peterborough. These included missed doses of medication, problems with an indwelling catheter and difficulties in obtaining continence pads. No one member of staff appeared to have responsibility for co-ordinating her care or liaising with the hospital or other services regarding her treatment and care.

“The quality of completion of prescription charts was at times poor in relation to both prescribing and dispensing of medication. The arrangements for clinical governance were not clear and it was difficult to understand where the prison fitted into the PCT structure. No member of the prison healthcare staff appeared to have the lead for clinical governance. Training and professional development plans for staff were

not available. Arrangements for clinical supervision and support for staff were not clear.

“The standard of record keeping was found at times to be of poor quality and did not comply with the Nursing and Midwifery Council standards.”

## **Primary Care Recommendations**

**Reception screening should be undertaken by someone who has the appropriate level of knowledge and training. This should include a preliminary assessment of mental health needs and challenging behaviours. The process should be audited on a regular basis to ensure that standards and quality of assessment are maintained and meet prisoners’ needs. All staff should be made aware of the referral process to the mental health in-reach team and the significance of CPA status.**

**A primary mental health service should be developed within HMP Peterborough which recognises the mental health needs of female prisoners. Protocols should be developed which are clear about the roles of the primary and mental health in-reach services.**

**Regular discussion and allocation meetings between the primary care and mental health in-reach team should be developed. Minutes should be taken and made available to staff. A mental health lead should be identified within the primary care team.**

**When a prisoner has complex physical and mental health needs, consideration should be given to the appointment of one member of the primary care team to act as a key worker who would work closely with the CPA co-ordinator. The role could include liaison with all agencies involved in the prisoners care plan. This would ensure that all staff have access to the current issues, concerns and actions taken.**

**All staff administering medication should adhere to Nursing and Midwifery guidelines. The pharmacy provider may be able to suggest methods of audit to address this. Guidance should be developed for staff to deal with those prisoners who regularly do not present to receive prescribed medication.**

**A comprehensive induction programme should be developed for all new staff which includes elements of jailcraft and preparation for working in the complex health environment that exists at HMP Peterborough. The programme should include the mental health needs of female prisoners and healthcare staff responsibility in relation to ACCT. Mentors for new staff should be identified at induction as this will enable a source of on-going support and supervision.**

**A framework for clinical governance should be developed and a lead for this identified within the primary healthcare team. Training and development plans should be identified for all staff as a result of annual**

**appraisal. A system of clinical supervision should be developed for all staff within the primary healthcare team.**

**A regular programme of audit in care planning and record keeping should be developed to ensure quality and standards are in line with best practice and Nursing and Midwifery Council regulations.**

**Primary care nursing resources to deal with minor psychiatric morbidity and to prevent overloading of in-reach services, need to be increased.**

### **Secondary mental healthcare provision**

180. When the woman first arrived at Peterborough in 2005, she was asked about her health as part of the standard procedure when prisoners are first received. She was referred for a mental health assessment and it was identified that she had been cared for in the community under the Care Programme Approach (CPA). Under CPA and MAPPA, Community Psychiatric Nurses and the National Offender Management Service work together to provide regular supervision. Yet, apart from having an initial risk assessment, much of this aspect of her care was disjointed. Peterborough did not appear to have worked to bring together the agencies with which she had had contact to make CPA effective.

181. The clinical review also finds that secondary healthcare provision was inadequate:

“The mental health needs assessment at HMP Peterborough (2006) identified the mental health in-reach team as under resourced. It is not clear what actions if any were taken to address this. In prisons a primary mental health service is able to filter referrals, deal with the primary mental health issues and refer appropriate cases to the mental health in-reach service. If this process is not in place, there is a risk of the in-reach team becoming overloaded with inappropriate referrals. The lack of a comprehensive primary mental healthcare service at HMP Peterborough put additional pressures on the mental health in-reach team.

182. Other findings include:

“The woman had complex needs due to the co-morbid presence of a pituitary tumour and a psychiatric disorder which is uncommon. She was diagnosed as having an emotionally unstable personality disorder but it is unclear if adequate attention was given to consider whether this was a primary personality disorder or secondary to her pituitary tumour. This may not have made any difference to the treatment she received but could have resulted in the recognition of the complexity of her needs, the requirement for enhanced CPA and consideration of referral for admission to a psychiatric hospital.”

183. The review continues:

“During her first period in prison, the woman was seen by a nurse from the in-reach team when in crisis and on one or two occasions by a psychiatrist. She was allocated an assistant psychologist who was described as the team member able to spend the most time with her. Although the assistant psychologist undertook her role well and brought about a significant period of stability, she did have limitations which she recognised and made clear to other members of the in-reach team. She also identified on several occasions that the woman required more specialised support than was available at HMP Peterborough. There is no evidence to suggest any action was taken to address these issues by those responsible for leading and managing the mental health in-reach team. The care she received from the in-reach team was often fragmented and crisis driven especially so in her second and third periods of imprisonment. Care was not provided in a planned and co-ordinated multidisciplinary way.

“The in-reach team lacked the regular input of a psychiatrist and this significantly limited the clinical leadership that such a professional often provides in setting clinical standards. The psychiatric contact that did take place was limited in its assessment and unfortunately did not trigger comprehensive planning of her care.

“It is not easy to understand why someone on an enhanced CPA in the community did not receive a similar level of care in prison. It is difficult to avoid the conclusion that her care suffered as a result of the issues identified in the Department of Health document ‘Personality Disorder, no longer a diagnosis of exclusion’ and at least during the second and third period of her stay in prison, she was being seen as a problem rather than somebody who had problems.

“The weekly in-reach team clinical meeting identified in the operational policy (2005) did not always take place due to time constraints and minutes were not taken when meetings did happen. No time was identified for case discussion or case presentation of complex cases.”

### **Secondary mental healthcare provision recommendations**

**Nationally available prevalence data on psychiatric morbidity in female prisoners, as well as the resources needed to adequately cater for them, should be seriously considered and the gap in resource provision for the in-reach service should be corrected.**

**The in-reach team need to have access to a psychiatrist on a regular basis in order to function effectively as a multidisciplinary team and benefit from the clinical leadership this role contributes to the team.**

**A system of clinical supervision should be developed for all practitioners within the mental health in-reach team which may include regular discussion of complex cases. Training and development plans should be identified for all staff as a result of the annual appraisal.**

**The in-reach team need to develop a culture that ensures personality disorder is not a diagnosis of exclusion.**

**Procedures for assessment, care planning and regular CPA reviews in line with recommendations of the Care Programme Approach should be appropriately implemented.**

**The weekly in-reach team allocation meeting should be formalised and minutes taken. Cases should be allocated based on clinical need of the patient and the skills required by the practitioner to provide assessment and care.**

**A regular programme of audit in care planning and record keeping should be developed to ensure quality and standards are in line with best practice and Nursing and Midwifery Council regulations.**

#### **Healthcare senior management**

184. The clinical review also considers the work of healthcare senior managers:

“It was unclear how staffing levels had been identified as the first Health Needs Assessment for the prison was dated 2006. The induction arrangements for preparing healthcare staff to work in HMP Peterborough were not clear, particularly in dealing with prolific self harm and the mental health needs of women. The PCT had been involved from an early stage in the planning and provision of some staff to the prison including seconding a member of staff to undertake the Healthcare Manager role. The arrangements for clinical governance, policy development, support and supervision for the PCT prison health staff were not clear.

“It appears that agreement could not be reached on the service level agreements and the PCT ceased to provide primary nursing services and associated administration in February 2008. At this point, the staff involved had the option to transfer employment to Kalyx which a number did. Several people we spoke to had concerns about the PCT’s role with the contracted out prisons as there is a lack of central guidance. The current situation appears to be that NHS Peterborough has no organisational view on its involvement but some individuals remain involved because they have always been. NHS Peterborough has asked for central guidance on this issue.

“Currently, there is a partnership board meeting, clinical governance and medicines management meeting all with some NHS Peterborough staff in attendance. The situation with GPs is described as more stable

now as the agency is able to provide more consistency of GPs. The pharmacy provider has changed and this seems to be helping with some of the problems regarding prescribing and dispensing.”

### **Recommendations for senior healthcare managers**

**Arrangements for clinical governance and policy development need to be agreed and formalised.**

**Senior management need to ensure that there is clarity in the roles of primary and secondary in-reach care. They also need to ensure that systems and processes are in place for the efficient and effective working of these healthcare providers and commissioners.**

**A Local Health Needs Assessment or one generalised from national prison health prevalence data needs to be strongly considered by newly opening prisons to ensure adequacy of resources and skill mix.**

**Senior management need to ensure there is adequate induction programme for new staff as well as provision for mandatory training and continuing professional development.**

**Senior management need to ensure that there are adequate systems of staff support and supervision which could also contribute towards reduction in staff sickness and turnover.**

**It may be helpful for HMP Peterborough and NHS Peterborough to agree and formalise interim working arrangements until there is clarity about PCT responsibilities in relation to contracted out prisons.**

### **Involving the woman’s family in her healthcare**

185. The woman’s parents were anxious that my investigators speak to the then Head of Healthcare. The woman’s father had had a meeting with her and the Head of Female Services concerning his daughter’s care. Unfortunately, the Head of Healthcare, who was on loan from the Primary Care Trust, left the prison after healthcare provision was taken over by Kalyx. I understand the woman’s parents’ disappointment that I have not been able to interview the former Head of Healthcare as accounts of their difficulty in securing appropriate care for their daughter are inevitably incomplete as a result. At interview, the Head of Female Services spoke of a difficult meeting attended by herself, the then Head of Healthcare, and the woman’s father, which was abandoned due to lack of progress. I am struck, however, that the family were left with the impression that their concern and letters were regarded as unwelcome. The woman herself described her father as “interfering” and felt that some healthcare staff made comments to her as a result of letters he sent to Peterborough. The prison GP note in her clinical record referred to her “constant litany of complaints”.

186. Whilst clinical decisions should be taken by clinicians, family involvement in the care plans for prisoners can be beneficial. It was after receiving a visit from the woman's mother, who was distressed, that her endocrinologist wrote to the prison to ensure that she was being prescribed the appropriate medication. I appreciate that the woman was an adult with the right to decide whether her parents should be included in consideration and planning for her health and wellbeing. Nevertheless input from her family could have been used to good effect, instead of which they got the impression that they were an irritant.
187. Prison healthcare staff are expected to obtain information from the prisoner's general practitioner in the community, but this did not happen in the woman's case.

**I recommend that, where appropriate and subject to the prisoner's consent, Peterborough strengthens links with prisoners' families, particularly when the prisoner has self-harm or mental health issues.**

**I recommend that healthcare should contact the relevant community clinicians of newly received prisoners to obtain a definitive list of the medications they have been prescribed.**

### **Safety of medicines**

188. The woman's clinical record shows that she took an overdose of medication on at least three occasions. More worryingly, post mortem and toxicology results revealed enough Tramadol in her system to have been fatal or to have hastened her death. The woman's partner described to police at interview how she and the woman were both able to hide quantities of tablets.

**I recommend that Kalyx healthcare reviews the dispensing of medication to prevent hoarding.**

### **Good Practice**

189. The clinical review has identified four areas of good practice which I endorse:

**The weekly multi-disciplinary complex needs meeting established in February 2008 which provides an excellent opportunity for all staff involved with prisoners with complex needs to meet and discuss progress.**

**The appointment of a Safer Custody Co-ordinator who has responsibility for the audit of ACCT reviews and closures.**

**The hard work and commitment of the staff we spoke to. Of particular note in connection with the care of the woman, was the work undertaken by the Assistant Psychologist, who took pains to understand her internal world, her needs and problems. She also recognised her own**

**limitations as a result of her inexperience and sought the necessary guidance and support.**

**The continued support and advice offered to HMP Peterborough staff from NHS Peterborough despite the lack of national guidance relating to PCT responsibilities in relation to contracted-out prisons.**

## OTHER ISSUES CONSIDERED

### Support for prisoners who are at risk of suicide or self harm

190. In relation to Assessment, Care in Custody and Teamwork, the clinical review comments:

“There were 94 attempts of self harm and suicide documented during the three occasions the woman was at HMP Peterborough. The staff we spoke to who knew her were aware that she was at risk of prolific self-harm. The ACCT procedures require a multidisciplinary approach if vulnerable prisoners are to be supported successfully. There is no evidence to suggest that any member of healthcare staff was involved in either the risk assessment or ACCT reviews of the woman between 8 December and 15 January 2007. All the reviews were undertaken by members of the discipline staff. Although a reference is made to refer her to the in-reach team, there is no evidence that this happened.”

191. The clinical review makes the following recommendations:

**A multi-disciplinary approach to the ACCT procedures should be agreed and developed. Written or verbal reports should be sought when individuals cannot attend reviews in person.**

**A programme should be established to audit the quality of the ACCT reviews and closures and to ensure that any action identified as necessary in the review is completed.**

**All new healthcare staff should undertake ACCT awareness training. This should form part of their induction and their attendance should be recorded.**

192. The woman was placed on an ACCT (and its predecessor F2052SH) several times over the periods she spent in Peterborough to enable staff to monitor and support her. Unfortunately, my investigators were unable to examine her ACCT/F2052SH documents prior to 8 December 2006 as they could not be found in the possession of the police or at Peterborough. In spite of this, there are many entries in her clinical record and F213SH forms documenting injuries which show the various and increasingly disturbing ways she harmed herself.
193. I have investigated the death of a male prisoner with a serious mental illness who spent a long period at Peterborough in 2007 before being transferred elsewhere. It is notable that an arrangement existed between his houseblock and the male healthcare centre where he could move between the two areas according to whether he felt fragile and needed additional support. Although I appreciate the constraints Peterborough faced in coping with many women with complex mental health needs, the woman would have benefited from a more person-centred approach. That she had a history of mental illness and was actively harming herself is beyond doubt. Yet I have been left with the

impression that staff resisted her having periods of respite in healthcare. Indeed, on 11 December 2006, three days after arriving in the prison as a high risk of self-harm having been under constant watch in a police station, she was told she would have to go to a houseblock without having a proper assessment of her needs.

194. The case review (which itself was unacceptably delayed, taking place three days after the woman had been placed on an ACCT instead of 24 hours) appeared to be little more than a statement of a pre-determined decision. Instead of her being at the core of the review, it reads as a mechanism for moving her elsewhere so that she could be “managed”. It was a process which was done to her, rather than one in which she was able to take an active part. It does not refer to the assessment which PCO C conducted and it is not surprising that the PCO did not have a recollection of being present when it was carried out. I am concerned there was no recognition that the woman had not been assessed or had a case review for three days.
195. Prison Service Order 2700 which sets down policy on suicide prevention and self-harm management says:

“... the assessor team must be notified (according to local protocols) that the ACCT Plan has been opened and an Assessor must interview the prisoner within 24 hours of the Plan being opened ... The first Case Review must be held within 24 hours of the ACCT Plan being opened.”

**I recommend that the Director ensures ACCT assessments and case reviews take place within the timescale set in PSO 2700.**

196. PSO 2700 also states:

“... a pre-discharge Case Review must take place before a prisoner is returned to ordinary location from being resident in the Healthcare Centre ... what healthcare will be doing to continue support of the prisoner must be clearly documented in the ACCT Plan.”

**I recommend the Director ensures a proper discharge plan is put in place when a prisoner moves from healthcare to another residential location.**

197. I acknowledge that healthcare resources are not infinite. It is clear, however, that Peterborough looks after many damaged and disturbed women with complex needs. I am pleased to learn of the Complex Needs meetings which appear to be making a real difference to the care of such women, and that Peterborough seems committed to trying different approaches. PSO 2700 on suicide prevention and self-harm management, which became nationally binding in 2008, addresses a far wider spectrum of issues in caring for prisoners than the earlier version of the same PSO that was in force at the time of the woman’s death.

198. So far as the conduct of Night Auxiliary Officer B is concerned, I note that, even though charges were not brought against him, the CPS was unequivocal in saying that he breached his duty of care towards the woman. He argued in one of his police interviews that he had not been trained in ACCT procedures. The Training Officer confirmed to the police that ACCT training was not given to auxiliary officers. I am told that it is now an integral part of the auxiliary staff training course. Auxiliary officers may not have duties which take them into constant contact with prisoners but, even at night, conversations can take place between a staff member and a prisoner through a locked cell door. Several entries in the woman's ACCT plan were made by night staff in response to conversations they had with her. I am pleased to learn that a training gap has been filled but it is very sad that it took her death before the omission was rectified.
199. On two occasions when the woman asked to speak with a Listener, she was told that they were not available at night. Whilst I appreciate that prisoners may be released or transferred to other establishments, crises can occur at any time of the day or night, not only within office hours. It is important that Peterborough trains and retains sufficient numbers of Listeners to meet the needs of its prisoners.

**I recommend that Peterborough trains and retains an adequate number of Listeners so that one is always available when needed.**

200. Of the five ACCT case reviews the woman had during her last period of custody, two were conducted with just one member of staff present and two had only two staff present. Whilst only staff with knowledge of the prisoner should attend a case review, they should be multi-disciplinary in nature. She was suffering from a number of health complaints and mental health problems. A review with only one person present could not cover all the elements contributing to her self harm.
201. The ACCT case review which SPCO B carried out on 12 January 2007 was due on that date, although there is little evidence to suggest that one would have been arranged but for the Deputy Controller's intervention. It was conducted by one person and, whilst I do not doubt her integrity, it appears to me that SPCO B may have been lulled into a false sense of security. She was sure she had established a level of rapport that the woman would hand over any hidden medication or ligatures. There is no concrete proof of how or when she obtained the quantity of Tramadol she had amassed, but it is evident that this must have been over a period of time.
202. Annex 8G paragraph 17 of PSO 2700 sets out the minimum number of staff who should attend case reviews:

“... one of the attendees must be the named Case Manager ... one a residential officer who works in the area where the prisoner is located and the other an appropriate member of non-discipline staff.”

**I recommend the Director ensures that the number of staff conducting case reviews complies with PSO 2700.**

**Improvements in safer custody and healthcare since the woman's death**

203. The posts of Safer Custody Co-ordinator and Deputy were created in April 2008. Part of their role is to quality-check ACCT plans. One of my investigators asked PCO A in January 2009 to describe her experience of ACCT since she had been at Peterborough. She replied that safer custody procedures were far clearer than in 2006. Refresher training for staff was more frequent and the operation of ACCT was more organised. Each ACCT plan now has a case manager. Dates of case reviews are more widely publicised so that there is more opportunity for them to be multi-disciplinary with healthcare or in-reach present. The PCO said that designated staff would check on-going records in open ACCTs and, whereas in the past, staff were unsure of what to write in an on-going record, comments are now more detailed. In turn, prisoners were being offered more support. This had led to staff being more accepting of ACCT rather than being "scared" of it as a policy. It was becoming far more integrated into everyday prison life.
204. In spring 2008, the Head of Female Services and the manager of the In-reach Team set up weekly Complex Needs meetings where staff from various departments in the prison met to discuss how to care for particular women with needs such as self-harm, mental health, physical health, disability, issues of violence, bullying and substance misuse. It encouraged the sharing of information and the co-ordination of resources.
205. Asked about measures that are now in place to distract women from self-harm, SPCO B spoke about two activities which have had positive feedback. The Gamelan project (which is open to all women) encourages them to find something that they enjoy. It focuses on Indonesian musical instruments and the participants get a CD of the music they have created and photographs of themselves playing. In addition, PCO C runs the Safe Programme for women who harm themselves or attempt suicide. Trained PCOs as facilitators encourage very small groups of women to trust the others within the circle and talk in an open manner with peer support. In addition, there are support packs which try to deflect boredom with puzzles, word games, art work or pictures to colour in.

**Adjudication hearing**

206. It seems to me that the Deputy Controller did as much as could be expected from any adjudicator. Peterborough was performing poorly at the time. Its safer custody procedures were weak. It is commendable that, in the absence of certainty that information given at the hearing would be acted on, the Deputy Controller undertook to warn as many people as possible.
207. The woman had been placed on report for having medication with the stated intention of killing herself. I frankly doubt that she should have been placed on report in the first place, but do not know whether PCO J took the decision

or whether it was made elsewhere. The Prison Service Order covering adjudications says that in cases of deliberate self-harm the care of the prisoner should be a priority and not a punitive response. I concede, however, that the hearing did become an opportunity to improve existing arrangements.

### **Relationship with her partner**

208. Romantic relationships and friendships between women prisoners are a distinctive feature of their imprisonment. Women in prison form strong attachments to others and friendships assume an intensity that may not be true of life in the outside community.
209. I investigated the death of a young woman in another prison in 2007 where the forming and break-up of relationships between women shaped their daily lives. Indeed, it was impossible to understand their lives unless romances between them were known and acknowledged by staff as well as other prisoners.
210. Clearly, I cannot know what lay behind the woman's relationship with her partner. Some staff thought it harmful as there was some speculation that the woman was interested in grooming her daughter or that her partner was being encouraged to harm herself. Whatever the motivation, the two women were close, had wanted to have a blessing in the chapel, and the woman was visibly distressed when her partner was transferred to Holloway. Her partner's departure would have left her feeling vulnerable. From the ACCT plan entries, I am pleased to learn that residential staff treated her sympathetically and did not make light of her upset. I simply underline that four days later she took her life.

### **Contact with the woman's family**

211. The woman's grandfather died during her last few weeks in Peterborough. She was not successful in obtaining release on temporary licence to attend the funeral. Regrettably, the documents concerning this decision have not come to light so I am unable to comment on its reasonableness. I am pleased to see that her ACCT plan was updated and the day of her grandfather's funeral was noted as a trigger or warning sign. The extracts from the letter she wrote to the Head of Female Services asking to be allowed to go to the service show that she was saddened by her grandfather's passing. It was disappointing to read the later inaccurate comments for the MAPPA panel in which a member of staff (not identified) wrote that "there was no reaction" by her on being told that her application had not been successful. She told the Deputy Controller that her decision to save up tablets and take her life was taken after being told she would not be able to go to the funeral.
212. The woman's parents spoke to my Family Liaison Officer and one of my investigators about the deep distress they felt after being told of their daughter's death by Norfolk police at about 4.15am on 16 January 2007. The officers were unable to provide much information. Further details were

available on Teletext before they were contacted by the Director at 5.00am. One of my investigators asked the police and Peterborough to clarify the sequence of events. The Director confirmed that he had drawn up a press release but assured the woman's father that the information in the press about his daughter's sentence did not come from him.

213. The notes of the hot debrief held after the woman's death show that Peterborough's contingency plans said that the prison chaplain should contact a prisoner's next of kin. It was argued at the hot debrief that it was:

"... much better to ask the local area police to inform the NOK face to face. NOK may then speak to the duty Director. Police protocols not fully compatible with the prisons."

214. The Deputy Director was appointed the family liaison officer. Unfortunately, he no longer works at Peterborough and my investigators were unable to obtain contact details for him at the time of asking. I have subsequently been informed that he now works for HM Prison Service at another prison.

215. PSO 2710 (Follow up to deaths in custody) considers how families should be told that a relative has died in prison. Whilst it acknowledges that there are opposing views it says:

"... the vast majority believe that the first contact must be made directly by the establishment so that the family recognise that the death is a matter of great concern to the establishment ... If the police are asked to break the news on the grounds only of distance (and this may sometimes be necessary) ... This option is generally poor practice for the following reasons: The prison should demonstrate its duty of care and show that it is taking the death seriously by making a personal visit. Failure to make a personal visit can sour the prison's entire future relationship with the family. Families who have experienced deaths in custody say they prefer a personal visit and regard anything less as a shirking of responsibility. The police officer deployed to speak to the family may not be trained in breaking bad news or know anything about prisons ... The police officer will have limited information about the incident and it is frustrating for families not to have access to all the information they want."

The advice in PSO 2710 is in line with what I believe to be the proper practice.

**I recommend that the Director of Peterborough draws up a local protocol which complies with the advice set out in PSO 2710.**

216. The woman's parents have questioned the recall decisions that led to her licence being revoked and her return to custody. From the material I have seen, it was not unreasonable for her to be recalled as there were legitimate concerns about her behaviour. She had received a substantial prison sentence for having expressed the intention to harm a child. Living at an address near to a school, without her probation officer's approval, properly

called into question the safety of the public. Given that she was a high risk, MAPPA level 3 offender, any risk that she might re-offend, however unlikely, had to be taken seriously. She then spent two months back in prison while the Parole Board looked at her case, approved her re-release and imposed additional licence conditions.

217. After being in the community for three months, the woman was recalled a second time after hospital staff said she violently resisted having a ligature removed from her neck. I was not present and cannot know what happened at the hospital, but again it was not unreasonable for her to be recalled if the probation officer had fears about her unpredictability and what she might do next. I accept that her parents feel she was treated unjustly. However, we live in a risk-averse age where public protection is paramount.

### **Staff training**

218. The Training Officer at Peterborough at the time of the woman's death told the police that all SPCOs were fully trained in ACCT procedures. This consisted of an ACCT foundation course which instructed officers on how to open an ACCT and when it should be done. Training for ACCT assessors instructed them on how to conduct an assessment and how to plan a Caremap. The final stage was Case Manager which determined how often observations and conversations should be carried out, ensured that reviews took place and whether an ACCT could be closed or remained open. This training was not given to an auxiliary officer. An auxiliary officer has four weeks' general training which includes two weeks and two days in a classroom, four days shadowing another auxiliary, and a week of nights shadowing an auxiliary. She confirmed that Auxiliary Officer B was fully trained as an Auxiliary Officer but the night duty part of his training record had not been signed off correctly. He did not receive any formal ACCT training, which is now an integral part of the auxiliary staff training course.

## CONCLUSION

219. The woman was a very troubled young woman long before she arrived at HMP Peterborough. She suffered from mental illness and had physical health problems, all of which necessitated much medication. She had been under the care of psychiatrists since 1998. Those who knew her spoke of her eloquence, creativity, and her gift in expressing herself in poetry, art and music. Recurring themes of children and childhood, sexual abuse and self-harm were evident in the conversations she had with staff and prisoners. The boundaries of where reality ended and fantasy began were blurred. Her offence, which spoke of committing - hypothetically yet plausibly – the murder of a child, brought her into custody and into an environment where severe self-injury and levels of mental disturbance are very high.
220. A report talks of prison staff “sometimes uncomprehending of the motivation that drives women to injure themselves as part of their daily (and nightly) routine”. To staff with little or no prior knowledge of how women in custody may express their life experiences through harming themselves, working at a newly-opened Peterborough must have been a challenging experience. I have quoted the Chief Inspector of Prisons’ reports at some length as I believe that the problems the first inspection of Peterborough uncovered speak for themselves. It was into this world that the woman arrived in June 2005 when the prison had only been open for a matter of months.
221. The difficulties experienced at Peterborough by a relatively inexperienced staff were immense. And it would be unrealistic to expect other than that living in an environment where systems were erratic, non-existent or fragile affected the prisoners within its care. Kalyx, the contractor which runs Peterborough, did have experience of opening a new prison for women. HMP Bronzefield, the first privately-run prison in England for women, was opened by Kalyx in June 2004. It too experienced some difficulties with the operation of healthcare, particularly with regards to primary mental healthcare. Yet, according to the Chief Inspector of Prisons’ report on Bronzefield a year after it opened, its suicide and self-harm management was good, the relationships between staff and prisoners were good, and it had staff and managers who were enthusiastic and ready to learn from experience. In retrospect, I wonder if Peterborough could have built more on the knowledge gained from Bronzefield’s initial operation.
222. The woman was determined in her efforts to harm herself using a variety of methods, and she did not shy away from the potentially lethal consequences of her actions. Her last case review could have increased the frequency of staff observations and thus lessened the opportunities for her to harm herself. However, this depended on all staff actually carrying out the required observation checks. Night Auxiliary Officer B singularly failed to do so. It is difficult to see how Peterborough could have totally eliminated the risks to the woman’s life. However, opportunities to reduce them were missed as a result of what I judge to have been systemic failures.

## RECOMMENDATIONS

The response in respect of each recommendation, received from the Prison Service, is recorded after each recommendation as follows:

For the Director of HMP Peterborough

**I recommend that the Director satisfies himself that all first reception healthscreens are conducted on the appropriate forms.**

This recommendation is accepted and the action completed. The Director says: 'Standard prison template now in place, this is based on the prison service model on electronic template.'

**I recommend that all recalled prisoners have a First Reception healthscreen.**

This recommendation is accepted and the action completed. The Director says: 'All recalled prisoners now have a First Reception health screen.'

**I recommend that the Director ensures ACCT assessments and case reviews take place within the timescale set in PSO 2700.**

This recommendation is accepted and the action completed. The Director says: 'Robust management check systems are in place. Shortfalls are addressed in a timely manner. This is reviewed monthly at the monthly Safer Custody Meetings. Full auditable trail in place'.

**I recommend the Director ensures a proper discharge plan is put in place when a prisoner moves from healthcare to another residential location.**

This recommendation is accepted and the action completed. The Director says: 'Discharge from Healthcare reviews are held for all clinical and operational admissions (except First Night Centre). These are multi-disciplinary, MHIT involvement in cases of those subject to CPA. The review outcome is translated onto the Caremap.'

**I recommend that Peterborough trains and retains an adequate number of Listeners so that one is always available when needed.**

This recommendation is partially accepted and the action continues to be reviewed at monthly Safer Custody meetings. The Director says: 'The fluid population (including PMU [Population Management Unit] pressures) impacts on the achievement of this. The Samaritans train prisoners so training is dependent on their availability. Samaritans SLA has been reviewed. A hold is placed where practical but prisoners are not held back from progressive moves.'

**I recommend the Director ensures that the number of staff conducting case reviews complies with PSO 2700.**

This recommendation is accepted and the action completed. The Director says: 'Regular training courses are in place for all SPCOs and nurses are trained to Case Manager level. Training is an agenda item at the monthly Safer Custody Meetings.'

**I recommend that the Director of Peterborough draws up a local protocol which complies with the advice set out in PSO 2710.**

This recommendation is accepted and the action completed. The Director says: 'This has been fully reviewed and Local Operating Procedure produced, ratified by SMT and implemented. This is reviewed annually.'

For the Healthcare Manager at HMP Peterborough

**I recommend that, where appropriate and subject to the prisoner's consent, Peterborough strengthens links with prisoners' families, particularly when the prisoner has self-harm or mental health issues.**

This recommendation is accepted and the action due to be completed this month. The Director, on behalf of the Healthcare Manager says: 'Funding has been secured for a Family Support Officer (due to take post in April 2010). ADFAM SLA reviewed and MHIT support the work. Case Managers consult with prisoners to obtain consent and views. The Chaplaincy Team and Prison Visitors involved in working with families.'

**I recommend that healthcare should contact the relevant community clinicians of newly received prisoners to obtain a definitive list of the medications they have been prescribed.**

This recommendation is partially accepted and the action completed. The Director, on behalf of the Healthcare Manager says: 'The number of new receptions outweighs resources available to complete but in cases of essential meds (Chronic Disease, Mental Health, Drug Treatment) this is actioned. GP details and consent is obtained on reception. Immediate needs are addressed by the Reception evening GP.'

**I recommend that Kalyx healthcare reviews the dispensing of medication to prevent hoarding.**

This recommendation is accepted and the action completed. The Director, on behalf of the Healthcare Manager says: 'The In-Possession Medication policy has been completed and revised procedures are now in place to incorporate individual risk assessments (including ACCT info and SH history) and spot checks by clinicians and wing staff.'

## Clinical Review recommendations for the Healthcare Manager at HMP Peterborough

**Reception screening should be undertaken by someone who has the appropriate level of knowledge and training. This should include a preliminary assessment of mental health needs and challenging behaviours. The process should be audited on a regular basis to ensure that standards and quality of assessment are maintained and meet prisoners' needs. All staff should be made aware of the referral process to the mental health in-reach team and the significance of CPA status.**

This recommendation is accepted and the action is due to be completed by the end of this month. The Director, on behalf of the Healthcare Manager says:  
'All reception health screens are conducted by staff with accepted competency levels. Mental Health nurses and GPs are available in reception to support the process. All reception screening staff will undergo training and must meet competency levels [set] by a Professor in Psychology.'

**A primary mental health service should be developed within HMP Peterborough which recognises the mental health needs of female prisoners.**

This recommendation is accepted and the action is due to be completed by the end of this month. The Director, on behalf of the Healthcare Manager says:  
'This service has been developed, negotiations underway with the Foundation Trust to further enhance the services available.'

**Protocols should be developed which are clear about the roles of the primary and mental health in-reach services.**

This recommendation is accepted and the action completed. The Director, on behalf of the Healthcare Manager says:  
'This has been reviewed and an integrated pathway completed.'

**Regular discussion and allocation meetings between the primary care and mental health in-reach team should be developed. Minutes should be taken and made available to staff. A mental health lead should be identified within the primary care team.**

This recommendation is accepted and the action is due to be completed by the end of this month. The Director, on behalf of the Healthcare Manager says:  
'Negotiations underway with the Foundation Trust to further enhance the services available. The integrated pathway will enhance this process and formalise the systems to ensure effective continuity of care. Following outcome of the negotiations all systems will be reviewed formally.'

**When a prisoner has complex physical and mental health needs, consideration should be given to the appointment of one member of the primary care team to act as a key worker who would work closely with the CPA co-ordinator. The role could include liaison with all agencies involved in the prisoners care plan. This would ensure that all staff have access to the current issues, concerns and actions taken.**

This recommendation is accepted and the action completed. The Director, on behalf of the Healthcare Manager says:

‘A Complex Needs Meeting has been established which is recognised as an example of best practice. This promotes and ensures multi-disciplinary working and effective case management from all disciplines.’

**All staff administering medication should adhere to Nursing and Midwifery guidelines. The pharmacy provider may be able to suggest methods of audit to address this. Guidance should be developed for staff to deal with those prisoners who regularly do not present to receive prescribed medication.**

This recommendation is accepted and the action completed. The Director, on behalf of the Healthcare Manager says:

‘A pharmacy audit has been completed in conjunction with a HMCIP Pharmacy inspection in June 2009. All actions have been addressed. This is addressed at Medicines Management Committee and via Clinical Lead/MHIT Lead liaison. For those subject to CPA stickers are placed on the prescription chart in order for staff to be alerted to advise MHIT if they become non-compliant or to follow up for a reason for non-attendance.’

**A comprehensive induction programme should be developed for all new staff which includes elements of jailcraft and preparation for working in the complex health environment that exists at HMP Peterborough. The programme should include the mental health needs of female prisoners and healthcare staff responsibility in relation to ACCT. Mentors for new staff should be identified at induction as this will enable a source of on-going support and supervision.**

This recommendation is accepted and the action is due to be completed by the end of June. The Director, on behalf of the Healthcare Manager says:

‘The induction programme must be formalised with the HR & Training department.’

**A framework for clinical governance should be developed and a lead for this identified within the primary healthcare team. Training and development plans should be identified for all staff as a result of annual appraisal. A system of clinical supervision should be developed for all staff within the primary healthcare team.**

This recommendation is accepted and the action completed. The Director, on behalf of the Healthcare Manager says:

‘Clinical Leads are in place. All staff have a programme for PDRs. Clinical Audit programme in place. The Clinical Supervision policy has been developed, awaiting

ratification. Key staff have identified Clinical Supervisor. Record Keeping and Caldicott Policy in place.'

**A regular programme of audit in care planning and record keeping should be developed to ensure quality and standards are line with best practice and Nursing and Midwifery Council regulations.**

This recommendation is accepted and the action completed. The Director, on behalf of the Healthcare Manager says:

'Clinical Audit Programme in place for 2010, all key elements addressed and regularity determined by risk assessment.'

**Primary care nursing resources to deal with minor psychiatric morbidity and to prevent overloading of in-reach services, need to be increased.**

This recommendation is accepted and the action completed. The Director, on behalf of the Healthcare Manager says:

'A dedicated Primary Mental Health service is now in place. Negotiations underway with the Foundation Trust to further enhance the services available.'

For the Team Leader of the Mental Health In-reach Service at HMP Peterborough and the Chief Executive of NHS Trust

**Nationally available prevalence data on psychiatric morbidity in female prisoners, as well as the resources needed to adequately cater for them, should be seriously considered and the gap in resource provision for the in-reach service should be corrected.**

This recommendation is accepted and the action is due to be completed by the end of June. The Director responded on behalf of the organisations and says:

'A formal Mental Health In-Reach service review has been undertaken which has also considered resources. The deficiencies in resources have been identified and full action plan in place with a Steering Group of representatives from PCT Commissioners, prison representatives and CPFT directors. This has been elevated to critical risk on the CPFT Risk Register.'

**The in-reach team need to have access to a psychiatrist on a regular basis in order to function effectively as a multidisciplinary team and benefit from the clinical leadership this role contributes to the team.**

This recommendation is accepted and the action completed. The Director responded on behalf of the organisations and says:

'A consultant psychiatrist is in place, dedicated to the MHIT.'

**A system of clinical supervision should be developed for all practitioners within the mental health in-reach team which may include regular discussion**

**of complex cases. Training and development plans should be identified for all staff as a result of the annual appraisal.**

This recommendation is accepted and the action completed. The Director responded on behalf of the organisations and says:  
'This is mandatory for CPFT (MHIT) staff and forms part of the PDR process.'

**The in-reach team need to develop a culture that ensures personality disorder is not a diagnosis of exclusion.**

This recommendation is accepted and the action completed. The Director responded on behalf of the organisations and says:  
'This forms part of the CPFT policy. There is a complex case team linked to MHIT. A qualified psychologist with a specialism in PD works within the MHIT.'

**Procedures for assessment, care planning and regular CPA reviews in line with recommendations of the Care Programme Approach should be appropriately implemented.**

This recommendation is accepted and the action completed. The Director responded on behalf of the organisations and says:  
'All MHIT case loads fall under CPA provisions and adhere to Section 117 meetings and after care provisions. Audit process is established and embedded by CPFT. New CPA paperwork has been designed to accommodate prison needs.'

**The weekly in-reach team allocation meeting should be formalised and minutes taken. Cases should be allocated based on clinical need of the patient and the skills required by the practitioner to provide assessment and care.**

This recommendation is accepted and the action completed. The Director responded on behalf of the organisations and says:  
'Formal weekly meetings are in place with daily briefings Monday to Friday. All are minuted. Weekly meetings have clear actions and outcomes.'

**A regular programme of audit in care planning and record keeping should be developed to ensure quality and standards are in line with best practice and Nursing and Midwifery Council regulations.**

This recommendation is accepted and the action completed. The Director responded on behalf of the organisations and says:  
'Clinical Audit Programme in place for 2010, all key elements addressed and regularity determined by risk assessment.'

For the Healthcare Manager, Director of HMP Peterborough and Chief Executive of NHS Peterborough

**It may be helpful for HMP Peterborough and NHS Peterborough to agree and formalise interim working arrangements until there is clarity about PCT responsibilities in relation to contracted out prisons.**

This recommendation is accepted and the action completed. The Director responded on behalf of all parties and says:  
'Since 2008 the responsibility for the provision of Primary Health services has transferred to Kalyx. A draft MOU has been developed and was due for completion March 2010.'

For the Director and Healthcare Manager of HMP Peterborough

**Arrangements for clinical governance and policy development need to be agreed and formalised.**

This recommendation is accepted and the action completed. The Director responded on behalf of both parties and says:  
'Clinical Governance Committee established with ToR reflecting the policy development needs and PSO.'

**Senior management need to ensure that there is clarity in the roles of primary and secondary in-reach care. They also need to ensure that systems and processes are in place for the efficient and effective working of these healthcare providers and commissioners.**

This recommendation is accepted and the action completed. The Director responded on behalf of both parties and says:  
'Negotiations underway with the Foundation Trust to further enhance the services available. The integrated pathway will enhance this process and formalise the systems to ensure effective continuity of care. Following outcome of the negotiations all systems will be reviewed formally.'

**A Local Health Needs Assessment or one generalised from national prison health prevalence data needs to be strongly considered by newly opening prisons to ensure adequacy of resources and skill mix.**

This recommendation is accepted and the action completed. The Director responded on behalf of both parties and says:  
'A full Health Needs Assessment has been completed in February 2008. A consultancy firm has been commissioned to complete Gender Specific Needs Assessments, [which were due to] be completed by Jan 15<sup>th</sup> 2010.'

**Senior management need to ensure there is adequate induction programme for new staff as well as provision for mandatory training and continuing professional development.**

This recommendation is accepted and the action completed. The Director responded on behalf of both parties and says:  
'All operational staff have a formalised induction programme which incorporates this.'

**Senior management need to ensure that there are adequate systems of staff support and supervision which could also contribute towards reduction in staff sickness and turnover.**

This recommendation is accepted and the action completed. The Director responded on behalf of both parties and says:  
'Staff Support Days have been implemented in line with PSO 2700'

**All new healthcare staff should undertake ACCT awareness training. This should form part of their induction and their attendance should be recorded.**

This recommendation is accepted and the action completed. The Director responded on behalf of both parties and says:  
'The induction programme must be formalised with the HR & Training department.'

For the Director of HMP Peterborough

**A multi-disciplinary approach to the ACCT procedures should be agreed and developed. Written or verbal reports should be sought when individuals cannot attend reviews in person.**

This recommendation is accepted and the action completed. The Director says:  
'OMU staff, seconded Probation staff and external offender supervisors will be invited to attend reviews where possible, or have the option to make a contribution either in written format or over the phone, prior to the review taking place. Invites highlighting the date and time of reviews will be issued by the Case Manager to the OMU unit. The security department will attend reviews where concerns have been raised regarding the prisoner's security information, again the case manager will issue a required notice to the security SPCO.'

**A programme should be established to audit the quality of the ACCT reviews and closures and to ensure that any action identified as necessary in the review is completed.**

This recommendation is accepted and the action completed. The Director says:  
'Management Check programme in place which supports the Safer Custody quality assurance checks. Issues raised and addressed at Safer Custody Meetings.'

## **GOOD PRACTICE**

**The weekly multi-disciplinary complex needs meeting established in February 2008 which provides an excellent opportunity for all staff involved with prisoners with complex needs to meet and discuss progress.**

**The appointment of a Safer Custody Co-ordinator who has responsibility for the audit of ACCT reviews and closures.**

**The hard work and commitment of the staff we spoke to. Of particular note in connection with the care of the woman, was the work undertaken by the Assistant Psychologist, who took pains to understand her internal world, her needs and problems. She also recognised her own limitations as a result of her inexperience and sought the necessary guidance and support.**

**The continued support and advice offered to HMP Peterborough staff from NHS Peterborough despite the lack of national guidance relating to PCT responsibilities in relation to contracted-out prisons.**