

**Investigation into the circumstances surrounding
the death of a woman at hospital in April 2011
while a prisoner at HMP and YOI New Hall**

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

August 2012

This is the report of an investigation into the circumstances surrounding the death of a woman. She died aged just 19 years at hospital in April 2011. On 14 April, she was found unconscious in her cell at HMP and YOI New Hall with a ligature around her neck. Staff gave her cardio-pulmonary resuscitation and she was taken by ambulance to hospital. Sadly, she died three days later without regaining consciousness.

The investigation was carried out by two investigators. A family liaison officer was appointed. The woman's family asked several questions about her time at New Hall and I hope this report helps to answer them.

A clinical review was conducted by a clinical reviewer on behalf of the local PCT. Staff and prisoners at HMP and YOIs New Hall and Peterborough, and the staff of the National Offender Management Service (NOMS) Women's Team co-operated fully with this investigation. I apologise for the delay in producing this report.

This is a sad story of a very young woman who had a long history of self-harm and challenging behaviour in prison. The combination of vulnerability and disruptive behaviour is complex and requires careful management. The Prison Service supposedly takes a national approach to cases such as the woman's and she was placed on the central register of women prisoners who cause disruption (commonly known as the DPP register). Unfortunately, this report sets out a catalogue of failures in her management while on this register at New Hall and two previous prisons, which calls the whole process into question.

The national Women's Team in NOMS, which is responsible for the register, was unable to explain why the woman was placed on it and appears to have lost sight of her various moves and the reasons for them. This suggests a systemic failure in which a very vulnerable young woman was transferred around the women's estate without adequate regard for her substantial needs. In particular, she was allowed to transfer to New Hall in November 2010 in contravention of various policies, taking her far away from her family and home area. This separation was an obvious part of her distress and made visits very difficult. Although she had regular telephone and letter contact with her grandmother, she had not had a visit from her family in the 16 months before she died.

I consider that her needs could have been better managed by a more holistic, multi-disciplinary approach based on enhanced case reviews designed to address the issues posed by such a complex young woman. Instead, this report illustrates that, too often, the response to her behaviour was by way of standard prison responses such as cellular confinement, segregation and being placed on the basic regime, rather than trying to identify and deal with the root causes. I hope that this disturbing report helps the National Offender Management Service learn appropriate lessons in order to improve the management of troubled young women.

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.

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Prisons and Probation Ombudsman

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SUMMARY

1. The woman came from South Wales and lived there with her grandmother from the age of three. At the age of 14 she began to get in trouble with the police and, in 2008, she was detained in a secure children's home. In May 2008, when she was 16, she received a sentence of three years detention for robbery and, after being released for only one day in November 2009, she was arrested on further serious charges and returned to prison.
2. After her return to prison, she initially spent time in HMP and YOI Eastwood Park, the nearest women's prison to her home, then moved to HMP and YOI Downview in Surrey and from there to HMP and YOI Peterborough in June 2010. In November 2010, she moved to HMP and YOI New Hall, in West Yorkshire, where she had previously spent time as a juvenile in the Rivendell Unit for girls under 18.
3. In July 2009, the woman was placed on the central register for women prisoners who cause disruption (commonly known as the DPP register) and continued to be on the register until her death. This meant that, among other things, the agreement of the national Women's Team was supposed to be obtained before she could be transferred between prisons.
4. During her time in prison the woman regularly harmed herself. Many of these incidents involved making superficial cuts to her arms or making ligatures, which she placed around her neck. (There is only one previous recorded occasion before her death when she tied a ligature to a fixed object.) As a result she was frequently monitored under suicide prevention procedures.
5. With the advance approval of the Women's Team, the woman was transferred from Downview to Peterborough on 18 June 2010, while she was subject to suicide prevention procedures.
6. At Peterborough, she continued to self harm and was found with ligatures on several occasions. She told staff that her main concerns were her distance from home, lack of visits from family and her grandmother's health. These concerns evidently figured prominently in her mind at Peterborough, and later New Hall, until her death. During her time at the prison she refused to engage with members of the mental health team and would often not participate in suicide prevention procedures.
7. On 18 November 2010, the woman volunteered at short notice to transfer to New Hall. Contrary to the procedures of the DPP the agreement of the national Women's Team was not sought or obtained. New Hall was not told that she was on the DPP register or subject to suicide prevention procedures.
8. At New Hall her challenging behaviour continued into 2011. She was said to be abusive to both staff and other prisoners and was held in the prison's segregation unit on several occasions, even when she was regarded

as at risk of suicide and self harm. She continued to make attempts to harm herself and was frequently the subject of suicide prevention procedures. She continued to refuse to engage with mental health services.

9. During her time at New Hall, the woman consistently told staff of her distress at being too far away from her family to receive visits and her wish to transfer to Eastwood Park to be closer to them.
10. Having set fire to her cell, she was transferred to the prison's unit for women in need of additional mental health support, known as 'Holly House'. Initially she continued to be disruptive and said she did not want to be on the unit, but she appeared to settle down and for the first time she began to engage with mental health staff.
11. Despite these improvements, the woman also experienced a number of set backs and continued to attempt to self harm. Many of these acts were recorded as being as a consequence of not only her behaviour, but also her continued frustrations at being far from her family.
12. In March 2011, staff at New Hall became very concerned about how vulnerable she was and her mental state was described as 'fragile'. New Hall made continued and increased efforts to arrange a transfer to Eastwood Park. Staff attempted to follow the stipulated requirements to transfer a woman on the DPP register but their efforts to arrange a transfer were impeded by bureaucratic processes required by the Women's Team.
13. Despite a transfer being agreed in principle, about which she was informed, she tied a ligature to a hand rail in the toilet area of her cell one evening in April. On discovering her, staff and paramedics were able to resuscitate her and she was taken to hospital. However, she sadly died three days later.
14. This report into the woman's death makes a number of recommendations, the most significant relating to the operation of the DPP register by the national Women's Team in NOMS and that governors are reminded of the importance of sharing information about women on the register.
15. The report also finds that her disruptive behaviour and her risk of self harm were managed separately through different and competing processes rather than through a holistic approach to addressing the underlying causes. A recommendation is therefore made for enhanced case reviews which could have given staff oversight of her needs, as well as supporting and challenging her. There is also a need to clarify national guidance on fire-setting. We do not consider her fire-setting should have been referred to the police; it could have been regarded as further self-harming behaviour and the possible criminal charges added further to her overall anxiety. We make several recommendations about suicide and self-harm management procedures, as well as the use of the discipline system. We make a recommendation about staffing arrangements on Holly House at New Hall and endorse other recommendations made by the clinical reviewer about her healthcare. Finally, recommendations are also made about emergency procedures.

THE INVESTIGATION PROCESS

16. This office was notified of the woman's death on 17 April 2011. The investigation was allocated to an investigator on the same day. Notices were issued to staff and prisoners at HMP and YOI New Hall telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. He did not receive any response to these notices.
17. The investigator spoke to the Deputy Governor of New Hall on 18 April to introduce himself. The case was opened by an Assistant Ombudsman on 21 April on the investigator's behalf. The Assistant Ombudsman met the Governor and members of the senior management team. He also met representatives of the Independent Monitoring Board (IMB) and the Prison Officers' Association (POA). (IMB members are unpaid volunteers from the local community who monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. The POA is a trade union for prison officers.)
18. Two investigators visited New Hall on 6, 7 and 8 June and interviewed ten members of staff and one prisoner. They also spoke to the Governor and members of the Safer Custody Team. Written feedback on emerging issues was provided to the Governor on 13 June. On 5 July, the investigators spoke at length to the Head of the Women's Team at NOMS. They also visited Peterborough prison on 13 July and interviewed a further four staff. Written feedback was provided to the Director of Peterborough after these interviews. Both investigators liaised throughout the investigation with a Detective Sergeant from West Yorkshire police and information was shared between the two organisations. We apologise that due to work load pressures the report has been delayed.
19. A qualified mental health nurse undertook a clinical review on behalf of the local PCT. He attended some of the staff interviews with the investigators and also visited the prison independently to complete his enquiries.
20. One of our family liaison officers contacted the woman's family to tell them about the investigation and to offer them the opportunity to raise any concerns about her time in prison. Her aunt raised a number of issues on behalf of the family:
 - in the light of her two previous suicide attempts at New Hall, what psychiatric/medical assessments did she have and was she was referred for mental health treatment?
 - why were the family not told about the two attempts on her life that she made at New Hall?
 - why was she in a cell by herself, given her state of mind, and what was the thinking was behind this decision?

- why was she moved to Holly House, away from two of her closest friends and might have heightened her feelings of isolation?
- what were the timings of her suicide observations and were they made correctly?
- why was she transferred to New Hall, because this made it almost impossible for the family to visit her?
- had she been bullied or victimised by staff at New Hall?
- why, following the previous attempts that she had made on her own life, was she put in a cell with an obvious ligature point, namely a hand rail?

It is hoped that these questions are answered at the end of the issues section of this report.

21. The family received a copy of the draft report as part of the Ombudsman's consultation process. As well as speaking to my family liaison officer they also provided written representations having considered the findings in our report. The family told the family liaison officer that they had been traumatised and distressed by reading the report and expressed their concerns over the findings of the report and its annexes. They reiterated a number of concerns identified by the investigation and explained how they felt that the report had highlighted what they believed to be really significant failings.
22. We are grateful to the family for the time they have taken to consider the report and the feedback they have provided. The investigator considered the issues raised and although the comments have led to no further changes in the investigation report we have included their following observations.
23. The family said they were concerned with the actions of medical staff in particular. They felt that the woman had required specialist help and that the system had failed to provide this. They also felt that she received inadequate care and that staff were not appropriately qualified to understand her specialist needs.
24. The family were further concerned with the conclusion of the clinical reviewer and disagreed with his findings in coming to a conclusion. The family also called into question the independence of the review and felt that the clinical reviewer was not suitably qualified to comment on resuscitation procedures.

BACKGROUND

HMP and YOI New Hall

25. HMP and YOI New Hall is a women's prison that holds adult women prisoners of all categories, young adult women and girls between the age of 16 and 18 in a special unit. The prison is in West Yorkshire between Wakefield and Huddersfield and holds up to 446 women prisoners. It also has a nine bed mother and baby unit.
26. In the Independent Monitoring Board (IMB) report for the period between March 2010 and February 2011, the board noted that the prison had suffered a substantial reduction in its budget and faced a challenging task to reduce spending without compromising the safety and wellbeing of staff and prisoners.
27. The IMB reported that staff-prisoner relations were generally good and that the safer custody team worked hard to monitor and address the issues of self-harm, suicide prevention and bullying. The IMB was positive about the prison's work with the large number of women at New Hall with mental health problems.
28. Her Majesty's Inspectorate of Prisons (HMIP) inspected New Hall in 2008. (The report of its most recent inspection in February 2012 is yet to be published.) HMIP noted that New Hall is a "busy and complicated" prison with a "needy and challenging" population. In common with other women's prisons, a significant number of women arriving at New Hall had serious substance abuse, mental health and self-harm issues. HMIP found that, commendably, New Hall had risen to the challenges posed by a diverse and complex population but there was much still to do. It was noted that Holly House was referred to as the healthcare centre, although it housed only women with mental health problems.
29. The Inspectorate was concerned that there was little consistent case management of women at risk of suicide and self harm. The quality of care plans and the effectiveness of case reviews varied and it was noted that some prison processes, such as moving women to the basic regime or using disciplinary procedures, conflicted with care arrangements for some of the most vulnerable women. In 2008, the Inspectorate noted that relationships between staff and prisoners were poor and there were some inappropriate attitudes to women with mental health issues. We understand that at the most recent inspection in 2012 significant improvements were seen, but there was still a concern that there was an insufficiently integrated approach to ensuring that vulnerable and troubled women received effective support in the segregation unit and elsewhere in the prison.

Mental Health Services and Holly House

30. Until 1 December 2010, mental health services in New Hall were provided by South West Yorkshire Mental Health Trust and mental health nurses provided 24 hour support. Since then, these services have been provided by the Offender Health Division of Nottinghamshire Healthcare NHS Trust. There are six mental health nurses in the team plus a team manager (at the time of her death one of the posts was vacant). The majority of the mental health nurses work from Monday to Friday between 8.30am and 4.30pm. In April 2011, the service was extended so that a mental health nurse starts at 7.30am to liaise with outgoing night staff and provide continuity of care. An extended duty worker stays at the prison until 7.00pm to cover late receptions, urgent mental health needs during the early evening and to dispense prescribed medication to the most seriously mentally ill patients. There is a mental health nurse based on Holly House between 7.30am and 7.00pm weekdays. The rest of the team spend most of their time in the main part of the prison. There are four psychiatrist sessions per week. A telephone on-call system was provided after 7.00pm and at weekends.
31. Holly House is a 12 bed unit for prisoners regarded to be in acute mental health crisis, those awaiting transfer to a secure mental hospital and prisoners thought to be going through a particularly bad time mentally. Although known popularly as 'healthcare', it is not for women prisoners with physical health needs. It is run by prison discipline staff rather than healthcare staff and is more akin to a social care unit. Referral to Holly House is dependent on individual need. Typically the unit runs at about 50% of capacity. All of the cells on Holly House are single occupancy. Four cells are fitted with cameras and two have Perspex doors for prisoners under constant observation. One of the cells is adapted for a disabled prisoner.
32. Holly House is managed by a dedicated senior officer who works on the unit Monday – Friday. In addition, three discipline officers work on the unit every day giving a high staff to prisoner ratio. Staff apply to work on the unit and are hand picked. They all receive basic mental health training and additional training according to need, such as in personality disorders and learning difficulty. Staff undertake educational and therapeutic work with the women such as baking and art therapy.

Sycamore House – Segregation Unit

33. Sycamore House, also known as the care and separation unit, is the prison's segregation unit. Women prisoners segregated from others for the good order of the prison or for their own protection are held there, as well as women serving punishments of cellular confinement following a disciplinary hearing known as an adjudication.
34. The IMB has to be notified of any prisoner's move to the unit within 24 hours. Before a prisoner can be authorised to remain on Sycamore House, a nurse assesses whether they are mentally and physically fit to be segregated. Final

authorisation is given by a governor. Additional authorisation is required for residents on open Assessment, Care in Custody and Teamwork (ACCT - see below for definition). IMB members visit Sycamore House at least once a week. There are also daily visits by governors and healthcare checks. Staff on Sycamore House complete a segregation history sheet recording daily observations on all the residents.

Disruptive Prisoners' Protocol (DPP)

35. The central register for women prisoners who cause disruption, (commonly known as the DPP register), sits within the overall allocation strategy for women prisoners. The aim of the register is described as being to:

“... ensure consistent, decent, honest, open and fair allocation of women whose behaviour causes disruption to the regime of an establishment ... It seeks to balance the needs of the individual women with the needs of the estate and provides the strategic overview to assist with ensuring a fair distribution amongst prisons reasonably able to manage and support them.”

36. In order to be placed on the DPP register a woman must fulfil the following criteria:

- is unwilling or unable to live with others and is likely to require lengthy periods of segregation
- OR her behaviour is significantly disturbing to other women, a risk to staff or is disruptive to the regime

In addition the woman is likely to display one or more of the following indicators:

- Multiple offences against discipline
- Repeated and prolonged anti-social behaviour
- Suicidal/self-injurious behaviour according to one or more of the following:
 - a) prolific and/or extreme self harming behaviour usually requiring medical intervention
 - b) actively suicidal
 - c) on constant observation for a lengthy period because of suicidal intent

37. When a prison identifies a woman who might require management on the DPP register they alert the national Women's Team. Before a woman can be placed on the DPP register, regular multi-disciplinary case conferences must take place and a care management plan agreed. The decision to accept a woman onto the DPP register is taken at bi-monthly Women's Team allocation meetings.

38. The DPP register is managed nationally by the Women's Team. It is their responsibility to agree decisions to transfer these women between prisons. The Head of the Women's Team has the final authority for the allocation of women on the DPP register. Membership of the register is monitored at the bi-monthly allocation meetings. Prison staff are responsible for creating individual care management plans for each woman on the DPP. Regular case conferences should be held to monitor progress on these plans and the minutes of these are copied to the Women's Team.

Assessment, Care in Custody and Teamwork (ACCT)

39. Assessment, Care in Custody and Teamwork (ACCT) is the National Offender Management Service's process for monitoring prisoners thought to be at risk of self harm or suicide. Any member of staff may open an ACCT document at any time. The initiating member of staff completes a concern and keep safe form detailing the reasons for opening the ACCT. The prisoner is offered access to the Samaritans telephone (a cordless telephone with direct access to a Samaritan that can be used in the privacy of their cell) and/or a Listener (a prisoner trained by the Samaritans to provide a confidential peer support).
40. An initial level of observation and number of conversations is set. The highest level of observation is constant, which involves the prisoner being located in a special cell and watched all the time. The next highest level is once every 15 minutes. This means that staff must visually check the prisoner once in every 15 minute period. Checks should be irregular to prevent the prisoner anticipating when they will occur. The number of conversations refers to the minimum number of times members of staff should seek to talk meaningfully to the prisoner. Good quality entries describing these interactions should be recorded on the on-going record.
41. The prisoner must be assessed by a trained ACCT assessor within 24 hours of the ACCT being opened. An action following assessment review then takes place. This review is charged with completing a CAREMAP (a list of the prisoners issues, plans to tackle them and people identified to undertake them) and scheduling the next review. At each review the level of observation and number of recorded conversations is revisited. Reviews should be multi-disciplinary unless there is good reason for them not to be (for example if the prisoner refuses to take part if healthcare staff are present). Reviews also decide whether the ACCT should remain open. If an ACCT is closed a post-closure review should be scheduled after an appropriate length of time agreed at the closing review. The post-closure review should check on the prisoner's feelings and how they are coping.

Adjudication

42. Adjudication is an internal disciplinary hearing held to decide whether a prisoner has broken Prison Rules. If a prisoner is found guilty they can be cautioned or received a range of punishments such as reductions or stoppage of pay and access to privileges, confinement to their cell or a combination of all of these. In some cases involving an alleged criminal offence the charges are referred to the local police and the adjudication is adjourned.

Control and Restraint

43. Control and Restraint (C&R) is when members of staff use various techniques in order to control a violent or unmanageable prisoner. C&R techniques should use only the force that is necessary to enable staff to cope competently and effectively with violent prisoners and potentially disruptive situations, with the minimum risk of injury to staff or prisoners.

Incentives and Earned Privileges Scheme (IEPS)

44. IEPS is a scheme run in all prisons whereby prisoners are granted privileges for reaching and maintaining certain standards of behaviour and compliance with their sentence plan targets. If standards are not maintained then the privileges can be withdrawn. There are generally three levels on the scheme – basic, standard and enhanced. The different levels of IEPS govern, for example, time out of cell, access to the gym, access to earnings and access to the telephone.

Good Order or Discipline (GOOD)

45. For Reasons of Good Order or Discipline is one of the circumstances under Prison Rules when prisoners can be segregated from the rest of the population. One of these is if a person is disruptive and incites others to be disruptive. Prisoners can be segregated for a maximum of 72 hours before the situation is reviewed. Usually prisoners on GOOD are held in the care and separation unit (Sycamore House).

Multi-Agency Public Protection Arrangements (MAPPA)

46. Multi-Agency Public Protection Arrangements are the arrangements in England and Wales for the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public. The "responsible authorities" overseeing MAPPA include probation staff, prisons and the police. MAPPA are coordinated and supported nationally by the Public Protection Unit of the National Offender Management Service.

National Offender Management Service (NOMS)

47. The national body that administers correctional services in England and Wales, through public and private prisons and probation trusts. The national Women's Team is part of NOMS and has policy responsibility for managing women prisoners.

Offender Assessment System (OASys)

48. The Offender Assessment System is used in England and Wales by NOMS, both in custody and the community, to measure the risks and needs of offenders under their supervision. It is a series of computer based forms assessing an offender's risk and outlining sentence and supervision plans. It is accessible by staff in prison and probation staff in the community and is designed to help communication between agencies.

Tackling Antisocial Behaviour (TAB)

49. Prisoners who are considered to be the perpetrators or victims of antisocial behaviour may be placed on a TAB plan. For perpetrators, the TAB process has three stages. In the first stage, staff monitor the prisoner's behaviour for seven days. The prisoner is not made aware that the TAB plan is open or that they are being monitored. In stage two, the monitoring continues but the prisoner is made aware of the TAB. The perpetrator might lose certain privileges if there is evidence of bullying or antisocial behaviour. In stage three, the perpetrator is placed on disciplinary report and may receive a punishment. If a prisoner is the victim of antisocial behaviour, they will be offered staff support.

KEY EVENTS

Background before the woman's transfer to HMP and YOI Peterborough

50. The woman was born in 1991, and brought up in South Wales. She lived with her grandparents and uncles from the age of three. She was very close to her grandmother and kept in regular telephone and letter contact with her while in prison. She was a troubled teenager from the age of 14. She had substance use problems and had a number of convictions for minor offences, most of which were committed while under the influence of alcohol.
51. In January 2008, when the woman was 16, she was sentenced to a four month detention and training order, which she served in a secure children's home. (A detention and training order is a custodial sentence for children imposed by the courts for persistent or serious offending and can last between four and twenty months.) In May the same year, she received three years detention for robbery. By July 2009, just one month after she had turned 18, she was placed on the DPP register).
52. The investigation team attempted to establish the sequence of events leading to her being placed on the DPP register. However, the Women's Team had no record of the reasons she was included on the DPP register, and was only able to say that she must have met the criteria at that time. They were unable to provide any detail about how she met the criteria or the discussion that led to the decision in her case, other than to say the process is set out in their policy document.
53. The woman spent some of her sentence in Rivendell Unit at New Hall (for girls 18 and under) but was released from HMP and YOI Eastwood Park (a women's prison near Bristol) on licence on 2 November 2009. The very next day she was arrested and charged with robbery with violence and returned to Eastwood Park.
54. Her probation officer wrote on the woman's recall to prison paperwork that she presented a high risk of serious harm and had a history of self-harm in a custodial environment. She subsequently received a further three year detention order in January 2010, for this offence. On her return to prison, she continued to be managed on the DPP register. She moved from Eastwood Park to HMP and YOI Downview (in Surrey) and then to HMP and YOI Peterborough on 18 June 2010. Despite being on the DPP register at the time of both transfers, Women's Team were unable to demonstrate to the investigation team that they had been informed of either move. Neither could the Women's Team explain why she was moved increasingly further away from her family, despite her age.
55. Her prison record shows a total of 14 incidents of recorded self-harm before her transfer to Peterborough. Of these, seven involved the use of ligatures and the remaining seven were superficial cuts made to her arms. (The term 'ligature' is used to describe when a person ties a cord, such as a belt, rope, shoe laces or other material around their neck as a means of self-strangulation.) None of the records for this period show that she tied the ligatures to anything and she did not require cardio pulmonary resuscitation (CPR) on any occasion. (CPR is an emergency procedure involving chest

compressions to maintain blood circulation and often mouth to mouth to push air into the patient's lungs.) In the aftermath of most incidents she was uninjured but occasionally staff reported slight redness to her neck. Several of the records note that the ligatures she tied were loose.

HMP and YOI Peterborough 18 June – 18 November 2010

56. The woman transferred from Downview while she was subject to monitoring on open ACCT. According to her records, the transfer was agreed in advance, although the Women's Team has no record of that agreement. The ACCT was opened on 5 June, after she tied a ligature when she was in her cell during lunchtime. According to the ACCT assessment, her main issue was concern about her grandmother's health and her desire to visit her. Reference was made to an application to have accumulated visits at Eastwood Park, the nearest prison to her home. (If a prisoner is not getting the visits they are entitled to, because of distance from their home for example, they can save up their visiting orders and apply for a temporary transfer for a short period of time when all the visiting orders can be used.) On her CAREMAP, she was encouraged to deal with the issue of her grandmother's health by herself, with no suggested staff support. At the time of her transfer to Peterborough, her possible transfer to Eastwood Park was not mentioned on her CAREMAP.
57. Her first ACCT review at Peterborough took place in reception on 18 June. Her main concerns were her distance from home, her lack of visits and her grandmother's health. She said she had applied for a transfer to Eastwood Park, and this action was added to her CAREMAP for the case manager to follow up. At her next review on 22 June, staff agreed to plead her case for a transfer to Eastwood Park. However, there was no evidence to suggest that they did so. At a review on 30 June, she said she had self-harmed by tying a ligature on her 19th birthday because she had not had a visit from her grandmother. She was said to be in good spirits and had spoken to her grandmother on the telephone. The ACCT was closed, despite there being no further progress on securing a transfer.
58. In July 2010, the report provided by Peterborough for the bi-monthly Women's Team meeting to discuss the DPP register, said that the woman had managed relatively well since her move to Peterborough and, one incident aside (where she spat at a member of staff), she had started to engage more appropriately. The report did not mention her ACCT or requests to transfer closer to her family.
59. On 2 August, she was charged under Prison Rules with attempting to assault a member of staff. She was taken to the segregation unit, known as the Separation and Care Unit (SCU) at Peterborough. She was reported to be angry that she was in the SCU and an ACCT was opened after she put a ligature around her neck when staff told her that she was to remain on the SCU for 72 hours for reasons of good order or discipline. An ACCT assessor spoke informally to her that evening and asked her whether she was a regular self-harmer. She said she did not like talking about it but volunteered that she had self-harmed 'the other day' but no one had found her. Prisoners with an

open ACCT should be segregated only in exceptional circumstances. However, there was no record of whether the appropriateness of her segregation was considered in her ACCT or elsewhere in her prison record.

60. The woman would not give much information at the ACCT assessment interview the next day. She would not tell the assessor whether the ligature represented an attempt to kill herself. At the subsequent review, following the assessment, she said she was angry but did not want any help to deal with this. She told staff she was close to her grandmother but had trust issues with talking to staff. A CAREMAP was completed with two goals – to improve contact with her grandmother and to work on her anger issues. She was recorded as responsible for achieving those goals herself, by interacting regularly with staff and using the telephone or writing letters “as and when required” to maintain contact with her family. Her adjudication was adjourned the same day and she returned to the prison’s young offender unit.
61. At another ACCT review on 4 August, the woman told staff that she had tied the ligature on 2 August, because she had been taken to the SCU. She was in a much better mood now she was back on the wing and the ACCT was closed. A member of the mental health team visited her but she told him she did not want to speak to him. The next day at 9.00pm, she was found to have blocked the observation panel in her cell door. Staff entered the cell and found her with a ligature around her neck. The ACCT form was re-opened. At a case review the next morning, 6 August, she would not say why she had tied the ligature. She told staff she was angry that a letter from her grandmother had gone missing. She thought it had been ripped up. A new CAREMAP was completed listing her main goal as increased family contact by letter and telephone. Once again it was noted that she was responsible for increasing her family contact.
62. At her next ACCT review on 13 August, she was reported to be feeling much better. She said she was in regular telephone contact with her grandmother and her only issue was the missing letter. She was working as a wing cleaner – a trusted position which provided her with more time out of her cell – and was thoroughly enjoying it. The ACCT was closed. It was re-opened on 18 August, after staff found she had blocked her observation panel at 8.25pm and had in her possession a ligature made from bedding. She would not explain why and refused to attend her ACCT case review the next day or one on 20 August. She went to a review on 22 August and was reported to be in much better spirits. The ACCT was closed again.
63. On 26 August at 10.00pm, the woman asked staff to take a ligature from her cell. She told them she did not have anything else in her cell that she could harm herself with. The ACCT was re-opened. The next day on 27 August, she was taken to the SCU after she allegedly assaulted an officer and later tied a ligature. She told staff at an ACCT review that her problems centred on the letter from her grandmother that had gone missing. The next day she returned to the wing and had another ligature made from her sheet cut from her neck at 3.50pm. At an ACCT review the same day she explained that she was upset that her grandmother’s letter was still missing because it was a loss of contact with her grandmother. In the record of the case review, the case manager recorded that the letter had been lost by accident.

64. She refused to attend ACCT reviews on 1, 2, 3, 4 and 5 September. At 9.00pm on 5 September, she was found with another ligature made from bedding, which was removed. On 6 September, she told staff that she had tied the ligature out of anger and frustration over the missing letter. She spoke openly about her good relationship with her grandmother and the fact that she was unable to visit her in Peterborough and again talked about a transfer to Eastwood Park. The CAREMAP was updated. Her first issue was listed as 'being at Peterborough'. The goal of her having a visit was set. The action to achieve this was for her to be transferred to Eastwood Park. However, no member of staff was given responsibility for achieving this and she herself was tasked with putting in an application for a move and saving her visiting orders (VOs) for accumulated visits.
65. At her next ACCT review on 14 September, the woman was said to be in good spirits. Staff noted that she was still a wing cleaner and worked very hard in the job. She had put in two applications for a transfer to Eastwood Park and one application for accumulated visits there. She had saved 13 VOs for potential accumulated visits. The ACCT was closed.
66. The September report to the bi-monthly Women's Team meeting repeated the July report exactly and offered no new information. No one from the Women's Team appears to have questioned why an identical report was submitted. There was no mention in the report of the ACCT form and the reasons behind it or the woman's desire to move to Eastwood Park and the applications she had made.
67. At 9.25pm on 13 November, an Auxiliary Officer (AO) noticed that the woman appeared low and tearful and unwilling to talk to him, which was unusual. (An AO, known as an Operational Support Grade (OSG) in public sector prisons, is a basic grade member of staff who will not have received the same level of training as a prison officer and will usually have much less interaction with prisoners.) She told him that she had put a ligature round her neck earlier but had taken it off. The AO opened an ACCT and told the night orderly officer (the officer in charge of managing the prison at night). She was reminded that she could have access to the Samaritans telephone and a Listener. Observations were set at once per hour with three conversations a day.
68. The AO reported on the ACCT record that the woman said she understood that the ACCT had to be opened but asked him if he would close it if she behaved herself. He told her that would be up to the reviewer. She had a quiet night.
69. She was seen by an ACCT assessor for her initial assessment interview the next morning, but would not discuss the previous evening. Her first case review took place at 10.50am and was attended by the unit manager, the ACCT assessor and a mental health nurse. She told the mental health nurse that she did not want any contact with the mental health team and did not want to discuss her concerns. The unit manager noted that a Prison Custody Officer (PCO) had reported that she had seemed in good spirits on the wing that morning. Observations remained at once an hour with three conversations a day and another review was scheduled for the following day. After the review, she told another member of staff that she was fine, had just had a 'weak moment' the night before and did not want to talk.

70. That afternoon the woman told a member of staff that she was happy and thought she would be transferred to Eastwood Park “soon”. At 6.35pm she was found with another ligature. Staff removed it from her and the nurse examined her but found no injury. The ACCT records that she had a quiet night and seemed in good spirits when she got up for breakfast and went to the gym the next morning on 15 November. She refused to attend her scheduled ACCT review at lunchtime. That afternoon she was reported to be in good spirits and helping with the laundry.
71. On 16 November, she joined in a badminton competition in the gym and played bench ball. At lunchtime she tied a ligature around her neck but was uninjured. That afternoon she attended an ACCT review. She explained that she had been emotional over the last few days because her grandmother was not well. She was encouraged to improve her status on the IEP scheme in order to be allowed more money on her PIN-phone account (the cash and card free phone system operated in prisons) and longer visits. Following the review ‘Family issues (Gran’s health)’ was written in the section listing possible triggers for self-harm. Her CAREMAP was updated to include the goal of ‘better contact with Grandma’ but again the responsibility for achieving that goal was placed solely on her. In the evening, she returned to the gym and was reported to be in good spirits and playing volleyball.
72. On 17 November, the woman had a long conversation with a PCO. She told him that she had spoken to her aunt the day before who had reassured her that her grandmother was OK. She said she was feeling much more positive as a result. The PCO told her he had arranged for her to go to the visits hall the next day so that she could have some photographs taken to send to her grandmother. He reported that she was very happy about this. Later the same evening, she asked staff whether she could transfer to Eastwood Park to be nearer her family, although no answer was recorded. Nevertheless, she appeared talkative and happy and was playing pool and laughing and joking with her friends.

Transfer to HMP and YOI New Hall 18 November

73. Two PCOs told the investigators that on the morning of 18 November, the woman was cleaning the wing when she heard that one of the women who was due to transfer to New Hall that day could not go because she was pregnant. One PCO said the woman said, “I’ll go, I’ll go, I bet you wouldn’t send me!” A Senior Prisoner Custody Officer (SPCO) asked her if she was being serious and she said that she was. He then left the wing to speak to a SO in operations to see if there was any reason that prevented her from moving to New Hall. He was told that there was not. There was no reference to her being on the DPP, on an open ACCT or any evidence of formal consideration of her move. The SPCO told her that her move had been agreed and asked her again if she was sure she wanted to move. She said she was and then went to her room to pack her property. A PCO escorted her to reception. She said she thought that she was becoming agitated at this point because she started to be “snappy” with the staff. She said to her, “I’ll be alright, I’ll be alright.”

74. Once in reception, the woman became angry when she was told she could not take certain items of her property with her because they were not listed on her property card. (Every prisoner has a card that lists all their possessions. Items that do not appear on it are regarded as not their property and are confiscated.) The Orderly Officer (in charge of reception) explained to her that she could not have the items and asked her to go to the escort vehicle. She refused and began shouting at him. She then aimed a punch at his face and other staff intervened and used control and restraint techniques to immobilise her on the floor. She then calmed down and walked on to the escort vehicle without further struggle.

The woman's time at HMP and YOI New Hall on Poplar Unit 18 November 2010 – 11 March 2011

75. The woman had an ACCT case review with an officer in reception at New Hall. She was recorded as “polite and chatty” and made a phone call to her grandmother. She was placed on one ACCT observation during every 30 minute period. She was described as in good spirits on arrival at New Hall. She was recognised by staff from her previous time there and laughed with them about behaving herself this time. She spent a quiet night in Oak Unit, the prison's first night/induction centre.
76. The next morning, 19 November, she was allocated to Poplar Unit. She attended an ACCT case review with two Senior Officers (SO) and was reported to be polite and chatty. She told them that she had not self-harmed for a while but was worried about her grandmother and the lack of contact with her. Her CAREMAP was updated with the goal of putting her grandmother's telephone numbers in her PIN phone account, which was completed promptly by staff, and it was agreed to keep the ACCT open at least until she had spoken to her.
77. On 22 November, the woman attended a sentence planning board. Also present were her Offender Supervisor - a probation officer seconded to work at New Hall by West Yorkshire probation service, her Offender Manager – her outside probation officer from Wales, and two members of Port Talbot Social Services. She told them that she did not want to remain at New Hall. She was given a target of completing the Thinking Skills Programme (TSP), gaining employment in a workshop and improving her behaviour to increase her chances of transferring to Eastwood Park. At interview, the Offender Supervisor said she was not aware at this point that she was on the DPP register. She thought that the social workers had mentioned it but she had denied it.
78. Although no one at New Hall claimed to know the woman was on the DPP register when she first arrived, nevertheless a report was submitted to the Women's Team monthly meeting in November to discuss the DPP register. The report said:
- “Caught up in recent YO [Young Offender] moves at Peterborough and volunteered to move. Making good progress on the biggest Res [residential] unit at New Hall, but early days as had already established herself in the drugs and gang scene. Intel and concern mounting but

not directly involved in drugs herself, probably provides the intimidation.”

We have not been able to establish who wrote this report. However, the meeting was attended by a governor, presumably in the absence of the governor with direct responsibility for managing the DPP register at New Hall. (He is responsible for first night and induction at New Hall). The investigation found no evidence to support the statement that the woman was involved in either the drug or “gang scene” at the prison.

79. She appeared settled on Poplar Unit over the next few days but did not attend her next ACCT case review on 25 November. The review noted in her absence that she had conformed to the unit regime and interacted well. She attended another review the next day with two SOs. She said she was feeling isolated because she did not know the prisoners or staff on the wing very well. The SOs persuaded her to give it a little more time and told her that she could speak to staff if she had any concerns. A note was made to make an appointment for her to see the probation officer because she had questions about further charges. She told them she had not self-harmed or had any thoughts of suicide following a recent death at the prison. Her CAREMAP was updated with the goal of getting to know her personal officer better and feeling more part of the unit. The onus was on her again to make contact with her personal officer, who was not recorded as attending her case review. (Each prisoner is assigned a personal officer who acts as the officer that they can turn to should they need help. This officer is also required to get to know the prisoner, have regular conversations with them and record these interactions.)
80. Over the next few days, the woman was reported to be mixing well on association and going to the gym and to the library. She was observed every 30 minutes and ‘conversations’ were recorded on her ACCT once every morning, afternoon, evening and night with extra entries at every staff handover. At her next ACCT review, on 2 December, she said she had been in touch with her grandmother but she was still feeling troubled and felt she would use a ligature. The next day at 7.21pm, she was seen sitting behind the privacy screen in her cell with a ligature loosely around her neck. A Principal Officer (PO) removed it and she told him that she was worried about her grandmother. He spent some time with her and told her he would talk to her again the following day. He completed self-harm paperwork and a local incident report form. No extra ACCT review was scheduled.
81. At 7.45pm the same evening, the woman told an officer that she was feeling much better. The next day she was reported to be fine and mixing well on the unit. Over the next few days, she went to work in the packing workshop and was frequently seen laughing and joking. She received a negative behaviour warning on 7 December, for not getting up early enough for work.
82. At her next review on 9 December, she told two SOs that she was still in touch with her grandmother. She said she had acclimatised to the wing and got to know staff better. She was described as composed and comfortable and made a good contribution to the review. She was a little defensive at first when asked about self-harm and said she had not received counselling for it. She said she would tell staff if she had any issues about self harm.

Observations were reduced to once in every hour. Her CAREMAP was updated with the goal of encouraging her to open up more about her impulses to self-harm and she was put on the waiting list to see a counsellor.

83. The woman had another mostly positive week apart from receiving two negative behaviour warnings on 10 December for not working well in the workshop and refusing to go to work. On 14 December, she stayed in bed too long at unlock and missed her shift in the workshop.
84. She had an ACCT review the same day and again she contributed well. She told two SOs that she did not like New Hall but understood that she was there because Peterborough was full. She said she was in contact with her grandmother by letter and telephone and this helped her. She also knew some of the women who had transferred from Peterborough with her. She said she was feeling much better and it was decided to close the ACCT. A post-closure review was scheduled for 21 December.
85. The woman received four further negative behaviour warnings on 15 and 16 December, for swearing at three different officers and saying she would love to punch another. Also on 16 December, by contrast, she volunteered to clean the education department and received a positive behaviour notation. However the next day she threatened an officer after he asked her to move away from another prisoner's door and received another warning.
86. Another ACCT was opened on 20 December, after she was found in her cell at 10.00pm sitting under her sink with a ligature around her neck fastened to the pipe. (This was the first and only time, before 14 April, that she was known to have fastened a ligature to something.) A mental health nurse was called to assess her but she would not talk to her. An immediate action plan was completed and she was put on observations every thirty minutes with conversations to be recorded once every morning, afternoon, evening, night and at every staff handover. She was offered an opportunity to use the Samaritans phone and speak to a Listener. She was not allowed to hold any of her medication in her possession. She settled down at about 10.30pm and spent a quiet night.
87. The next morning at 9.45am, an officer took the woman through an ACCT assessment interview. She told him that she felt depressed. She had not had a visit from her family for over a year and said she wanted to go to Eastwood Park because this was the closest prison to her home and she would be able to have visits. She said she had wanted to die the previous night and felt "half and half" about whether she wanted to be alive today. She said she used to cut herself but had been using ligatures for about two years. She said part of her wished she was dead and she thought she would use a ligature again. She said she thought about her family but could not stop the feeling of wanting to use a ligature. She saw a mental health nurse but would not open up to the nurse. She told the officer that she did not want to work with mental health staff.
88. The next ACCT review took place at 11.15am the same morning. The woman attended and contributed but again found it hard to talk openly about her self-harm. She said her main concern was the distance from her family. She said she was moved from Peterborough due to overcrowding but wanted to

transfer to Eastwood Park so she could receive visits. She said she had friends on the unit that she talked to and was aware of the support offered by staff. It was agreed to keep the ACCT open even though she pointed out that she talked regularly about the future. Her CAREMAP shows two action points. The first was to complete a transfer request to Eastwood Park, which she said she was already in the process of doing, by writing to the Governor of the prison. A senior officer was assigned to support her with this, but there was no record of whether that assistance took place. The other action on the CAREMAP was for mental health staff to make contact with her.

89. The woman had an IEPS review on 22 December and was downgraded to basic regime because of a poor attitude to staff. The next day her CAREMAP was updated to reflect this. As a consequence of being on the basic regime, her television was removed from her cell. She was offered in-cell activities but declined them. Because she was on basic she spent most of the next few days over Christmas in her cell. At some point she had her television returned because over the next few days she was observed watching television as well as listening to music, reading and writing letters. On 29 December, she attended education and joined in with calendar making. The next day she was part of a film analysis class but did not like the film so spent some time doing a crossword instead.
90. A member of the mental health in-reach team (MHIRT) visited the woman later the same day, 30 December. This was the appointment requested at the review on 21 December. She told the nurse that she did not want to work with her.
91. At 6.45pm on 1 January, she did not respond when checked by an officer. She was found sitting behind her privacy screen with a ligature around her neck made from clothing. She would not say why she had tied it. A nurse was called but she was not injured except for a slight redness on her neck. She is recorded to have fallen asleep straightaway and to have slept well. No extra ACCT review took place in response to her tying this ligature.
92. The woman attended an ACCT review on 5 January and had her IEPS level reviewed at the same time. She was recorded as displaying a poor attitude. She told staff she had no thoughts of suicide and self-harm but that if she did she would not tell staff. She said she was not bothered about remaining on the basic regime. Family contact was explored and she said that this was very good with regular letters and telephone calls. A SO asked her how she would feel about staff having to break the news to her family that she had succeeded in fatally injuring herself with a ligature. She claimed not to be bothered and said she hoped her family would understand. There was no recorded discussion about her transfer to Eastwood Park, despite it being an action on her CAREMAP. Although her risk of suicide/self-harm was assessed as low, it was decided to keep the ACCT open in the light of her attitude and refusal to work with the mental health team. Her observations were reduced to once in every hour.
93. On 10 January, a positive entry was made about the woman's behaviour because she put 100% effort into her education class, was pro-active and a good team member.

94. On 11 January, the Offender Supervisor replied to a number of wing application forms submitted by the woman asking for a transfer to Peterborough or Eastwood Park. She told her that she needed to move from basic regime to standard regime in order to stand a good chance of being accepted by another prison. She also told her that she needed to confirm whether she was subject to the DPP because this would affect her transfer. The same day the Offender Supervisor sent an email to the Public Protection clerk at New Hall to try to find out if this was the case.
95. The woman had a positive week and at her next ACCT review, on 12 January, she was returned to standard regime. She was reported to be very positive and looking forward to starting a call centre course in education. She said she had no thoughts of self-harm and would speak to staff if she did. She said she had applied for accumulated visits to Eastwood Park. It was decided to close the ACCT form and a post-closure review was scheduled for 19 January.
96. On 17 January, the Offender Supervisor met her and told her that she had arranged accumulated visits for her at Eastwood Park. The woman told her that she no longer wanted the visits and wanted a permanent transfer to Peterborough instead. She submitted another wing application form the same day telling the Offender Supervisor that she was neither on basic regime nor subject to DPP and advising her to “get off ya arse and do something for a change”. The Offender Supervisor replied that she did not appreciate aggressive applications.
97. On 18 January, the woman was downgraded to basic regime again after receiving four negative behaviour entries since returning to standard regime on 12 January. She began the review with “an attitude” but relaxed and engaged well when things were explained to her. She was told that an improvement in her behaviour would help with her application to transfer to a prison closer to home. The same day she received a positive behaviour note on her record for applying herself well to the call centre course, working hard and being respectful.
98. On 19 January, an officer held the scheduled post-closure ACCT review. She said she was coping well and had no thoughts of suicide or self-harm. The officer was satisfied that the ACCT should remain closed.
99. On 24 January, a SO called her to the SO’s office to discuss an incident on the exercise yard when she had allegedly made a comment to another prisoner in an aggressive manner. The SO explained to her that she was placing her on the second level of the tackling anti-social behaviour protocol (TAB). The SO said she became threatening, abusive and then refused an order to return to her cell. She was taken back under control and restraint and the SO charged her with a disciplinary offence.
100. The next day the woman was taken to Sycamore House, the segregation unit and had disciplinary hearings for two charges. She was found guilty and she received eight days cellular confinement in punishment, which meant that she would be kept on Sycamore House until 1 February. She received five days cellular confinement for one charge of disobeying an order and a consecutive punishment of three days cellular confinement for another charge of

disobeying an order. Although it was not entirely clear from the records what the second charge related to, we believe she refused a mandatory drug test.

101. Also on 25 January, she was visited by the Offender Supervisor. She told the woman that a transfer to Peterborough was not possible while she was on basic regime and subject to the TAB process. She apologised for her aggressive application of 17 January and explained that she really wanted a transfer. The same day, the Head of Offender Management attended the Women's Team meeting to discuss the DPP register. The update on the woman was recorded as:

"Appears to have settled at New Hall, is currently on basic regime and ACCT plan but is engaging with staff. She has also started a work placement this week and has no negative reports. Still very early days for her."

The Head said she had only become aware that she was on the DPP register when the Women's Team had requested the update for this meeting. The representative from Peterborough apologised to her at the meeting for the fact that she had been transferred to New Hall on a normal draft by mistake. There was no recorded discussion at the meeting about her individual needs, in particular the possibility of her transferring to Eastwood Park.

102. The woman's segregation history sheet records that she was pleasant and polite throughout 26 January. She asked the Head during the Duty Governor round about her transfer. The Head recorded "advice given" but no detail of what this was. She also received routine visits from the Chaplaincy and a nurse. She said she was "managing" on Sycamore House.
103. On 27 January, the woman spent most of the day in bed. She refused a request from staff to clean her cell. Later she asked for a telephone call but when an officer told her she could not have one she replied, "fuck yourself and shove the phone call up your arse". According to the segregation history sheet she pressed her cell bell a number of times during the evening to ask for her property. She was told that staff would ring Poplar Unit about it, but she became abusive and continued to ring her bell.
104. At 7.10pm that evening, a third ACCT was opened after she was found in her cell with part of a sheet made into a ligature. Again she would not tell staff why she had made the ligature. Observations were set at once during every 30 minute period with conversations to be recorded once in the morning, afternoon, evening, night and at every staff handover. She was offered access to the Samaritans' telephone and a Listener, and the ligature was removed from her cell. There was no review about whether the segregation unit was an appropriate place to hold a young woman at risk of suicide or self harm.
105. The woman refused to take part in an assessment interview the next day, 28 January. The action following assessment section recorded that she did not want to engage in the ACCT process at all and speculated that her level of risk might be influenced by her current location on Sycamore House. She said at the review that she did not know if she wanted to die and she did not know why she tied ligatures. The CAREMAP was completed with the goal of

preventing her making ligatures by teaching her further coping mechanisms. It was decided that she would receive daily support from a mental health nurse to help achieve this. She was moved to a 'safer' cell containing fixed moulded furniture designed to prevent ligatures being fastened, but remained in the segregation unit. Neither family contact nor her request for a transfer to Eastwood Park was mentioned on the CAREMAP.

106. Her segregation history sheet records that she told the Duty Governor that she had no concerns on Sycamore House but wanted to transfer to Peterborough or Eastwood Park so she could have accumulated visits. A security information report submitted the same day resulted in her being placed on TAB level two for allegedly making comments to another prisoner.
107. The next day on 29 January, the woman again asked the Duty Governor about a transfer to Peterborough. He recorded that she was "in good spirits". He advised her that Peterborough would not accept her while she was on basic regime and being managed under stage two of TAB. At 4.00pm she was described as becoming abusive when she asked for something (not specified) and did not get it. At 7.40pm, she began banging her head against the wall of her cell. She refused to see the nurse who was called to examine her. At 11.05pm she was found in the toilet area of her cell with a ligature around her neck for which she would give no explanation. The night orderly officers entered her cell and removed the ligature.
108. On 30 January, she appeared to be in good spirits in the morning and made a telephone call to her family. At 4.40pm however, she was seen sitting at the foot of her door and would only respond to staff in a muted tone. Two officers and the unit SO went into her cell. She attempted to assault one officer and was restrained. She calmed down and apologised to him and then passed a settled evening. She was charged with breaking Prison Rules the same evening. The following morning all the required segregation paperwork was completed again. She was seen by a mental health nurse who recorded that she was bored. However, the nurse recorded no suggestions to tackle her boredom, given her restricted regime. Again, there was no review of whether segregation was appropriate for a young woman on an open ACCT.
109. The woman was found guilty of assaulting an officer at her adjudication. She received seven days cellular confinement as punishment and remained in the segregation unit. She was visited by a mental health nurse for her daily check and was pleasant and polite. The nurse wrote on her ACCT that no mental health issues were observed or reported.
110. On 1 February, she attended an ACCT case review in the segregation unit with three members of staff and two mental health nurses. She chose not to contribute very much to the discussion but said she had tied ligatures before and might do so again. She told staff she did not have any problems and appeared "nonchalant". The Community Psychiatric Nurse recorded on the on-going record that she had not been very communicative at her review and would be assessed further by mental health services.
111. Over the next week, the woman was often reported to be in good spirits. She was seen daily by mental health nurses but did not raise any issues and the nurses did not report any concerns. On 4 February, she was moved to

another cell in the segregation unit that had moulded furniture. At 11.00pm that night, she put a cut strip of bed sheet under her door but was observed to be asleep for the rest of the night. The next day she spoke to the Duty Governor on his daily visit to Sycamore House. They talked about her application for accumulated visits at Eastwood Park and he told her that this would not happen until her ACCT was closed.

112. On 7 February, she spoke to her Offender Supervisor in workshop 3. She told her that she was about to do the TSP course and asked if she could pursue a transfer to Peterborough once she had completed this. The Offender Supervisor said she would be happy to look into this for her.
113. On 8 February, she spoke to the Duty Governor on his daily round and again asked about a transfer. He repeated that Peterborough would be unlikely to accept her without an improvement in her behaviour. He wrote that she had accepted this. She attended an ACCT review the same day with a SO and a nurse. She was in good spirits because she was due to return to Poplar Unit the next day. She said she was not interested in participating in the ACCT process. Despite this it was noted that she had not self-harmed since the ligature that prompted the ACCT to be opened and the ACCT was closed. A post-closure review was scheduled for 16 February. (In fact there had been two ligature incidents while this ACCT was open, on 27 and 29 January.)
114. At 5.00pm on 14 February, a SO went to see her in her cell on Poplar Unit. They had had an altercation earlier in the day when the SO had reprimanded her and she had been returned to basic regime. The SO noticed that she was hiding her arms from her and was tearful and upset. The SO persuaded her to show her the arm and she saw that she had toilet roll wrapped around it. She agreed to see a nurse and the SO opened another ACCT. Observations were set at once every 30 minutes.
115. An assessment interview took place the next day with an officer. At the interview the woman said she had "family problems" and was fed up with being in New Hall because she was unable to have visits. She said that she had cut her left arm out of frustration and to relieve stress. She was adamant that the cuts represented a coping mechanism and not an attempt to take her own life. She told the officer that sometimes her self-harm was done with the intention to kill herself but most of the time it was not. She said she had no current thoughts of suicide and did not want to be dead.
116. The woman attended the action following assessment review and contributed well. She said that she had on-going issues with her location in New Hall and thought that staff were looking into transferring her to Eastwood Park. It was decided to close the ACCT and make further enquiries about her transfer. The same day it was written on the CAREMAP that a telephone call had been made to the relevant department about her transfer but the outcome of the call was not recorded.
117. She also had a review of her TAB status. An officer noted there had been no evidence of further bullying and she was allowed to return to work.
118. On 16 February, a SO met her to hold a post-closure review of the ACCT that had been closed on 9 February. She said she felt much better and had no

current thoughts of self-harm or suicide. She re-iterated that she used self-harm by cutting as a coping mechanism and the SO decided that the ACCT should remain closed.

119. The Offender Supervisor also spoke to the woman on 16 February about her request for a transfer. She explained to her that she needed to have a period of stable behaviour before a transfer could take place. At that time, HMP Morton Hall was changing role from a women's prison to an immigration removal centre which meant that a large number of women had to be transferred elsewhere. She told her that this would mean a transfer was unlikely before March.
120. On 21 February, an officer held a post-closure review with the woman for the ACCT that had been closed on 15 February. The officer noticed that she seemed much happier than she had been the previous week. She said she felt settled and was feeling good. She said there were no issues that she needed support with and the ACCT remained closed.
121. She made cuts to her arm again on 24 February. An ACCT form was opened and observations were set at once in every 30 minute period. At 10.22pm that night she handed staff a note that she had written to a SO describing her feelings. In the note she said that she did not normally speak to people but felt that the SO was someone she could speak to. She said she thought she should speak or she would "do something really bad to myself", even though she didn't want to. She said she did not want to hurt her grandmother. She finished:

"O-M-G I can't believe I'm gonna tell ya this my head is propa fucked up I swear since the last couple of weeks and it's getin worse like I've wanted to tie myself tite to my bed and set myself on fire and tie something round my pipe then tie tite round my neck and run the fast as I can and other stuff too. But I've stopped myself and it was hard but it's still comin to my head."

Because she was on an open ACCT, staff on duty read the note and the night patrol checked her more frequently than required by the ACCT until she went to sleep.

122. At her assessment interview with an officer the following day, she explained that she had cut herself because she was upset that staff in reception had lost letters and photographs sent in by her family. She said she did not tell staff that she had self-harmed because she did not want them to know she had done it. She said she was close to her grandmother and her grandmother thought she no longer self-harmed. She wanted to move to a prison closer to her home but thought no other prison would accept her. She said she had not been sleeping well and had been given medication for this. She also said she "hated" being monitored under the ACCT process because she did not like being checked on. She acknowledged that she felt suicidal and would not assure the ACCT assessor that she would not try to hurt herself.
123. The woman had an IEPS review with a SO on 25 February. The SO spoke to her at length about the frequency of her negative behaviour warnings (two since a review on 18 February). She persuaded her that she should engage

with the mental health team to help her and made an appointment for her to be assessed.

124. She had an ACCT review the same day with a SO and an officer. She said she did not want to be on an ACCT and would talk to staff when she felt able to do so. The SO wrote that someone from the MHIRT had visited her and completed a basic assessment. A follow up visit was planned for the following week. The ACCT remained open and observations remained at once every 30 minute period. A CAREMAP was completed with the goal of finding the missing items sent in by her family. Reception staff and she were jointly responsible for finding the items.
125. On 1 March, during an ACCT case review a SO updated the CAREMAP, "She feels her care plan needs have been met as she does not want to contribute to any part of the ACCT document." During the review, she said she was unwilling to talk to anyone about her problems, including mental health staff. There was no discussion about whether the missing items had been found. After a telephone discussion with a mental health nurse, the ACCT was closed and a post-closure review was scheduled for 7 March.
126. The woman had another IEPS review with a SO on 3 March and was returned to standard regime. On 7 March, she had an ACCT post-closure review. She was reported to be feeling much better with no thoughts of suicide or self-harm. There was no discussion about the missing items identified on the CAREMAP, or her possible transfer to Eastwood Park. On 8 March, she had a TAB review with a SO and was upgraded to level one because there was no evidence she had been involved in bullying since her last review and she had received positive comments from staff.
127. On 9 March, she went to work in workshop 3. She was charged with breaking Prison Rules by refusing a direct order to take her hands off her head and do some work. She was then asked to leave the workshop but refused to do so and pressed the general alarm bell. She was charged with refusing another order. According to her electronic prison record, she was removed from the workshop under restraint for refusing to hand in her tools and return to Poplar Unit.
128. An officer wrote an entry on her case note history that the woman returned to Poplar Unit in a "foul mood" and was threatening to "cause havoc". She told staff that she would not be at work the next day because she would be on Sycamore House for hitting someone. She also threatened to "do" one of the governors if she saw him.
129. At 9.45pm on 10 March, she rang her cell bell and showed an Operational Support Grade (OSG) cuts she had made to her neck and left arm. The night orderly officer and assistant night orderly officer entered her cell and called a nurse to look at the cuts. Cuts to her left arm were closed with steri-strips and dressed and cuts to her neck were also dressed. An ACCT was opened with observations set at once every 30 minute period.
130. An assessment interview took place the next day at 9.45am with an officer. The woman refused to take part in the assessment and would not answer questions.

131. Immediately afterwards a SO held a case review with the woman and the officer. The SO wrote that she did not like discussing her problems but that some of her barriers had been broken down recently. She said she had spoken to her grandmother the day before and it was a good conversation. She said her problem was being at New Hall and she would like to move nearer home. She also said that the cuts she had made to her neck were a new departure for her and had scared her, which is why she had pressed her cell bell. The CAREMAP was completed, this time with the goal of her being transferred to Peterborough. However, it was noted that Peterborough was currently oversubscribed. She was the person made responsible for securing the transfer by improving her behaviour and no date was given for when this was to be achieved.
132. An officer recorded in the ACCT on-going record that at lunchtime, the woman became upset that a friend of hers had been moved to Sycamore House. At about 1.20pm she lit two fires in her cell, one behind her door and one behind her privacy screen. Two SOs put out the fires and retrieved her, who they found unresponsive on the floor. The emergency response nurses were called and they gave oxygen to revive her. An injury report form indicated that she was shaking and in shock but had no signs of smoke inhalation or burns. An ambulance was called at the beginning of the incident but she refused to be examined by the paramedics.
133. Staff decided to move her from Poplar Unit to Holly House so that she could be monitored. She was unwilling to do this, wanting to be moved to Sycamore House to be near her friend, and was moved to Holly House by force. However, because of her vulnerability and the seriousness of her fire-setting, staff decided that Holly House was the most appropriate location. There were more staff on Holly House, all of whom had mental health training. The decision was made to move her to Holly House to offer her more support than she would have received on Sycamore House, the segregation unit.
134. The woman told staff different reasons for setting the fire. On 24 February, she told staff that she was thinking about setting herself on fire as a means of self harm. However, after she had set the fire, she told a nurse that she did it because she thought she would be relocated to the segregation unit to be close to her partner. (In a subsequent conversation on 17 March, she told a psychiatrist that she set the fire because she wanted to kill herself.)

Holly House 11 March – 14 April 2011

135. The woman was placed into an unfurnished cell (a cell with the minimum of unsecured cardboard furniture, anti-rip bedding, no ligature points, a clear Perspex door and a camera) on Holly House. She was given anti-ligature clothing to wear during patrol state and her lighter was removed. (Anti-ligature clothing is made from material that is extremely hard to rip. Patrol state is the term used to describe the times when prisoners are locked in their cells and there is a minimal number of staff on duty.)
136. At 2.45pm a SO and an officer held an ACCT case review without her, who refused to attend. No one from healthcare attended. The SO wrote that she was not communicating with staff at that time. She thought she had hoped to

be relocated to Sycamore House with her friend. She said her impulsive behaviour might lead to further attempts of suicide or self-harm and therefore she was placed on observations every 15 minutes and was to remain in the camera cell.

137. Also on 11 March, the woman was charged with breaking Prison Rules by intentionally or recklessly setting fire to any part of a prison. At 7.30pm staff entered her cell after she did not respond at a check but she was found to be well.
138. On 12 March, she spoke to a member of the Chaplaincy but refused to attend her adjudication for setting the fires. The adjudication was adjourned and the charges were referred to the police. At 7.40pm she was seen sitting on the toilet covered in blankets and banging her head against the sink panel. Staff went into the cell to make sure she was alright. At 7.00am the next morning an OSG wrote on the ACCT on-going record that he had contacted the night orderly officer because he had seen her asleep on her bathroom floor and she was not responding. She had also blocked the observation panel in her door. The night orderly officer managed to wake her and she went to sleep in her bed.
139. On 13 March, the woman was seen by staff banging her head in her cell. A nurse examined her and could not find any injury. At 7.00pm she pressed her cell bell and asked to talk to an officer. She asked her what would happen about her adjudication for setting the fires and how long she would be on Holly House. The officer talked to her for some time and said she tried to make her understand that the fires she set could have resulted in serious harm to several people. She advised her that the best thing she could do was try to engage with the people who were there to help her. The officer said she listened to her but told her she did not like talking to people.
140. The woman attended an ACCT review the next day on 14 March at 11.00am. A SO led the review and an officer and a nurse (the acting team manager for the mental health team) also attended. The SO wrote that she was still unwilling to contribute to the ACCT process but had listened to advice given about engaging with mental health services. It was decided to keep her on irregular observations of no longer than 15 minutes apart.
141. The same day, she was taken off the TSP course after she displayed “unpredictable and non-compliant behaviour”. It was decided that her behaviour was persistently disruptive and that she should be segregated for reasons of ‘good order and discipline’ (GOOD). She was downgraded to basic regime again. Normally in these circumstances she would have been moved to the segregation unit, but the decision was made to keep her on Holly House so that she could be monitored by healthcare staff.
142. A nurse completed the initial segregation health screen and recorded that the woman was uncommunicative. The Governor’s authority form was signed by a governor. This form specifies what activities are permitted during the period on GOOD. It was decided to allow her to attend visits and access the showers, telephone, unit library, unit education and unit exercise. She was not allowed to go to work or the gym (activities that took place outside Holly House). A review was scheduled for 17 March. She was located in a camera

cell with a Perspex door and placed in anti-ligature clothing. A SO talked to her and they agreed that if she had a settled day and night she could be moved to a more private cell and come out of anti-ligature clothing.

143. That afternoon the Offender Supervisor visited her on Holly House. The woman told her she was OK. She said she did not know why she had been removed from the TSP course and the Offender Supervisor told her she would try to find out. She sent an email the same day and received a reply from the TSP treatment manager explaining that she had not started the course because of the state of her mental health the day before. The treatment manager said that she would be able to go on the next course if her mental health improved.
144. The woman had a quiet day and night and the next morning on 15 March, a SO wrote in her record that she could move to a more private cell and “go into greys” (wear a prison issue tracksuit) as agreed the night before. She spent the morning writing letters and told staff she was fine. She was observed at irregular intervals of no longer than 15 minutes as required by her ACCT. At 1.30pm staff noticed she had blocked the cell camera. At 2.30pm she refused to move to another cell and struggled with staff when asked to do so. Later that day she was charged with breaking Prison Rules by disobeying a direct order to move cells. She spent between 5.00pm and 8.00pm sitting in the toilet area of her cell. She refused to speak to a nurse but went to sleep at about 10.15pm and appeared to sleep well.
145. The same day, 15 March, the Offender Supervisor sent an email update to the woman’s Offender Manager (community probation officer) to say that she told her the fires she set were not a suicide attempt. She was working with mental health staff but not engaging that well. The Offender Supervisor said that she had promised her she would do all she could to get her a transfer closer to home if she completed the TSP course. She had been doing well before she set the fires. The Offender Supervisor said that her placement on the DPP meant that special permission was needed to transfer her. She said one of the governors was pursuing a transfer to Peterborough or Eastwood Park.
146. On the same day, 15 March, the Head of Offender Management sent an email marked ‘high importance’ to the Deputy Head of the Women’s Team. She said that the woman had been involved in a potentially fatal incident when she set fire to her cell. The Head said the woman’s main issue was her allocation to New Hall because she was from Wales and was not receiving visits and that she wanted to return to Peterborough or Eastwood Park. She asked for advice about who she needed to contact to arrange a transfer for her. This was the first recorded evidence of anyone at New Hall seeking her transfer to Eastwood Park.
147. On 16 March, the woman was not very talkative and she shouted at staff when they checked on her. In the afternoon she was visited by the Head of Offender Management, the Duty Governor, and a nurse. That morning, the Head had received a reply to her email of 15 March about the transfer. The Deputy Head of Women’s Team told her that someone had taken over responsibility for the DPP register and transfers. She said that the DPP register needed to be looked at as a whole before a decision could be made about transferring her.

148. The next morning on 17 March, the woman went to her adjudication on Sycamore House but the hearing was adjourned until 24 March, so she could get legal advice. She returned to Holly House. The same day her segregation under Rule 45 for good order and discipline was reviewed. The review was attended by two governors, a nurse, a SO Parker and an officer. It was decided that she should no longer be segregated. It was noted on the form that staff were trying to get her a transfer to Peterborough. A governor wrote that she was to remain on Holly House in an attempt to get her to work with mental health staff. The removal from Rule 45 was to enable her to begin to take more part in the daytime regime on Holly House.
149. The woman had an ACCT case review that afternoon with a SO, an officer and a nurse. Two governors also attended for part of the review. She contributed well and agreed to re-do the assessment interview originally held on 12 March. She said she felt low in mood and angry. She felt isolated from her family and had not had a visit for 14 months. She wanted to be transferred to a prison closer to home. She rated her mood as five out of ten. She had been prescribed anti-depressants but had not started taking them. She said that some of her self-harm was with the intent to end her life. The CAREMAP recorded that a governor would look into the possibility of a transfer for her. Her ACCT checks remained set at four times an hour but she was no longer required to wear anti-ligature clothing. She remained on the basic regime, which meant that she was not allowed out on association but could eat meals on the unit so that she had limited interaction with staff.
150. After the review the woman met the prison psychiatrist and two nurses. They had a long discussion about the fire setting. The psychiatrist wrote in her electronic medical record that she told them she wanted to kill herself. She also described her emotions changing from minute to minute. Most of the time she felt angry or sad. She talked about her childhood. The psychiatrist said she appeared distressed and agreed to start anti-depressants to help lift her mood. A nurse was allocated as her case worker.
151. Also on 17 March, a caseworker sent an email to the Head of Offender Management asking for an update on the woman's sentence planning targets, whether it was true she had declined accumulated visits at Eastwood Park and for an explanation of the circumstances in which she had left Peterborough in November 2010. The Head replied the same morning after contacting the Offender Supervisor for details. She explained that the woman had come to New Hall accidentally and Peterborough had apologised for the error. She outlined her sentence planning targets. The caseworker replied asking for her conditional release date from prison and why she had not completed the TSP course.
152. The next morning on 18 March, the woman went to Sycamore House for the adjudication relating to the charge for refusing to work on 9 March. She received 50% stoppage of earnings for seven days as punishment. Afterwards she came back to Holly House where she attended an education class and worked on her art project. At about 1.20pm, when all the prisoners were locked in their cells over lunchtime, she pressed her cell bell. Two officers found her with a ligature round her neck. She was seen by a nurse

but was uninjured. Female officers then supervised her putting on anti-ligature clothing.

153. Her next ACCT case review was brought forward to the same afternoon. A SO, an officer and a nurse all attended. She was described as “not very communicative” but agreed to wear anti-ligature clothing during patrol states and at night because she did not feel safe. This decision was to be reviewed at the next ACCT review on 21 March. The SO also noted that she was due to start her anti-depressant medication that night. The CAREMAP was updated, although nothing was added to the note that the Head of Offender Management was looking into her transfer to Eastwood Park. Her low mood was to be treated with the anti-depressants she had been prescribed. She was to wear anti-ligature clothing as agreed until she was regarded as safe from harming herself. Her observations remained at four times an hour.
154. She passed a quiet few days, mixing well with others and working well in the education class on Holly House. On 21 March, she attended an adjourned adjudication for the charge of disobeying a direct order on 15 March. She was found guilty and punished with 50% stoppage of earning for two weeks, forfeiture of canteen (access to the prison shop) for two weeks and forfeiture of association for two weeks, suspended for three months.
155. An ACCT review took place later the same morning attended by a SO, an officer and a nurse. The woman did not speak openly and after much discussion it was agreed that mental health staff would no longer attend the reviews because she had trust issues with them. Instead, she agreed to talk to mental health staff just before each review. It was hoped that this would encourage her to open up more to staff during the reviews. It was decided to let her wear her own clothes during the day to try to build up trust. She was still required to wear anti-ligature clothing at night. She said that her self-harm was a spontaneous act and her problems stemmed from her past. Observations remained at once in every 15 minute period.
156. On 22 March, she saw a nurse in the mental health clinic on Holly House. She told him that her impulse to self-harm was greater in the evenings. She said she visualised throwing herself head first out of her window. She said she was concerned about her grandmother’s health, about which she felt uninformed because she had not had a visit for some 14 months. She said if her grandmother died, she would also die because she did not think she could cope without her. He suggested that staff ring her grandmother to establish what the home situation was but she declined his offer and told him that her grandmother would not talk to staff because she was secretive and told no-one about her health. Instead she said she would speak to her aunt to try to find out how her grandmother was. She said she was taking her anti-depressants but had not seen any benefit yet.
157. She saw the nurse again on 24 March with a psychiatrist. Her childhood was discussed and she referred to traumatic experiences, which she agreed to discuss in the future. She told the psychiatrist that the anti-depressants had been helping to keep her mood relatively stable.
158. On 23 March, the Head of Offender Management (returning to duty from leave) had picked up the email correspondence from the caseworker. She

found out from the Offender Supervisor why the woman had not completed the TSP course and replied to the caseworker. The caseworker in turn replied on 25 March asking for further details. She sent another email shortly afterwards. In it she said:

“As per the Allocation Strategy, prisoners should not normally be transferred unless individual Sentence Management Plans (including Life Sentence Plans), OASys and Public Protection (including MAPPA) documentations/assessments are completed, hence why I have asked [Offender Supervisor] to confirm the position in relation to her sentence plan.

“Also in the strategy it outlines the expectation that staff in establishments will tailor an individual Care Management Plan, then monitor its progress, or otherwise at subsequent case conferences and Women’s Team should be copied into minutes of all case conferences held. We don’t appear to have any minutes to assist us with making an informed decision. If you could let me have copies of this it would be really helpful.”

159. The woman also had her ACCT review on 25 March, with a SO and an officer. Input from a mental health nurse was given before the review as agreed previously. She spoke quite openly. She told staff that she did not like being on Holly House but understood the reasons she was there. The SO gave her positive feedback about her behaviour. Although it was noted that her self-harm was unpredictable her observations were reduced to twice an hour in recognition of her recent stability. The requirement for her to wear anti-ligature clothing at night was removed.
160. On 28 March, she was upgraded to standard regime in recognition of a sustained period of good behaviour since arriving on Holly House. This meant that she was allowed out of her cell during association periods on the wing. According to her ACCT record, this made her very happy and she went to education and participated well, joining in with conversations and appearing to be in good spirits.
161. On 29 March, she moved to cell H2-05. This was equipped to house disabled prisoners and contained an adjustable hospital bed and hand rail next to the toilet in the recess area. It was a bigger, lighter room than her previous room, had a view of the garden and was closer to the wing office. It was seen as a progressive move for her and a reward for her continued good behaviour. Her property from her cell on Poplar Unit was brought up the same day so she could move into her new room with all her belongings.
162. Later that day, the woman saw a nurse in the mental health clinic. She told him that she had talked to her grandmother recently and had found out that she was having back and hip problems and might need an operation. She said her mood was better since taking her anti-depressants.
163. On 30 March, an officer told her that she had made preliminary enquiries with the Head of Offender Management about the possibility of speaking to her grandmother by video link. Various emails were exchanged the next day exploring this possibility. The Offender Supervisor sent an email to her

Offender Manager asking for her help. She received a reply the same day saying that it would be difficult to arrange a video link as the facilities were in restricted areas. During the evening the woman had a telephone call with her grandmother and was reported to be “elated” afterwards. She talked to staff more openly and went to the gym as well as education.

164. The next day on 31 March, the woman saw the psychiatrist. She told him she felt stressed and had been having nightmares but was not as worried about her grandmother.
165. At an ACCT case review on 1 April, she was reported to be in a positive frame of mind. The review took place with a SO, an officer and a nurse. She was described as “much better in herself” and contributed well with good eye contact. She was noted to be engaging really well with staff and mental health nurses. Her observations were further reduced to once every hour.
166. Two days later on 3 April, an officer recorded on the woman’s electronic prison record that she had been pleasant and polite all weekend and was engaging much more with staff and other prisoners. At 10.15pm that evening her ACCT on-going record shows that she gave an OSG an envelope containing material that could have been used as ligatures and asked him to throw it away. The OSG made an entry in her on-going record, but no further action was taken. She then slept through the night.
167. On 5 April, an officer had a long conversation with her about her potential transfer to Eastwood Park. The officer said she was aware she needed to have a period of consistently good behaviour and she had made a good start. At 9.55pm, the night patrol officer checked her and was unable to see her in her cell. The night orderly officer was called and she was found with a ligature in the toilet area of her cell. The ligature was removed but she would not talk to staff.
168. The next day on 6 April, the woman had an ACCT review with a SO and an officer. A nurse gave some input but did not attend the review. She was again said to be in a positive mood despite having tied the ligature the previous night. The ligature was described as “loose”. She told staff that she had tied it after being encouraged to do so by another prisoner on Holly House and was said to be trying other coping strategies. She appeared very positive about working towards a transfer to Eastwood Park. During education the same day, another prisoner assaulted her and was removed from the unit and taken to Sycamore House. She was also taken back to her cell. An officer made an entry in her electronic prison record making it clear that she had not provoked the incident and had shown some restraint in not retaliating. The officer said that she had had a positive day, had interacted well and taken part in education.
169. On 7 April, an officer had a long conversation with her in the education room. She asked her if, should she die, she could donate her heart, lungs and other organs to her grandmother to prolong her life. The officer told her that it was an admirable thought but that it would be the last thing her grandmother would want.

170. A nurse saw her on her ward round at lunchtime with the psychiatrist. She admitted she had been tying ligatures of increasing tightness made from strips of her clothing. She said she found it hard to stop her impulse to tie ligatures. She handed the nurse the pink nightdress she had made the ligatures from and said she had thrown the smaller pieces away. Observations were increased to four times an hour and an ACCT review was scheduled for that afternoon. An officer wrote in the wing observation book that she had given a nurse a t-shirt that she was using to tear and make ligatures from. The nurse spoke to her and she told him that she had put the strips from her t-shirt in the bin. The t-shirt was thrown away.
171. An ACCT review took place at 3.15pm with a SO, an officer and a nurse. The woman said that sometimes she tied ligatures with the intention of dying. She said she knew it was risky but could not always prevent her impulses. She said she would ask for anti-ligature clothing if she felt unsafe. Her observations were agreed at irregular intervals of no longer than fifteen minutes. That afternoon she went to the gym and education and appeared to be in a positive frame of mind. Observations appear to have remained at once every hour until corrected to once every fifteen minute period the following day.
172. The same day 7 April, the Head of Offender Management sent an email to the caseworker in reply to her email of 25 March. In it she said:

“I understand the need for documentation, SP [sentence planning] targets, management plans etc for a resident on the disruptive protocol.

I have forwarded to you everything we have. Staff at New Hall are becoming increasingly concerned with her welfare. We received her a few months ago from Peterborough by mistake on a normal draft. They apologised and we were happy to work with her. At this time we were not aware of any information such as targets, family concerns, mental health issues or sentence plan targets.

Her mental health state has been described this morning as ‘fragile’ by the mental health lead. He has asked if we have a decision to move. She is very close to her family, who cannot visit her and this is the reason for her distress. She describes feeling of hopelessness with the situation and the distance she is away from her family. We are currently trying to facilitate a video link with her grandma from the probation office in Wales.

I feel that New Hall have tried to facilitate as much information as we have gained in her time here. We are now in a position where a vulnerable young woman requires a transfer back closer to her family as soon as possible. I understand your request for information as per allocation policy. However this case does require some urgency due to the fact that this was not an agreed transfer based on the allocations policy.

Can I please ask that a decision is made to enable us to structure her expectations as soon as possible.”

The caseworker replied the same day thanking the Head for the information. She said it was encouraging that the woman's attitude and compliance with the New Hall regime had improved because a transfer should not be agreed due to poor behaviour. She said she would discuss her transfer with the Deputy Head of Women's Team on her return from leave on 11 April, and recommend a transfer to Eastwood Park.

173. On 8 April, the woman went to Sycamore House for the adjudication relating to the charge of disobeying an order on 9 March. She received a caution and returned to Holly House where she saw a nurse in the mental health clinic. She asked him the same question she had asked the officer about donating her organs to her grandmother. She said she was concerned about the charges she faced in relation to the cell fires and was worried she would get an Indeterminate Sentence for Public Protection (IPP – in effect a life sentence with a set minimum time to serve and release only with the agreement of the Parole Board). Generally she said she felt hopeless and helpless about moving to a prison closer to home. The nurse agreed with her that he would contact her grandmother.
174. The nurse spoke to the woman's grandmother that afternoon. The grandmother told the nurse that she did not tell her grand-daughter some things because she did not want to worry her. Her hip operation had been postponed for a year and she had no other health concerns. The nurse told her that her strategy of not telling her everything was having a negative impact on her. He went to see her after the telephone call and tried to reassure her about her grandmother's health. He said she still insisted there was something else that her grandmother had not disclosed but could not explain why she thought this.
175. At 12.30pm on 10 April, the woman did not respond when her cell was checked. Two officers opened the door and found her sitting behind it with a shoelace around her neck and covered in her dressing gown. A nurse was called but no treatment was required. She would only say to staff that she found it hard to talk. Later that day she told an officer that she had "a lot going on in her head" but would not say what. He asked her if she wanted to die and she replied by shrugging her shoulders. The next day she was reported to be in good spirits and joining in with activities. She came out for association in the evening and chatted to an officer, telling her that she had other charges hanging over her head (relating to the cell fires she set on 11 March).
176. On 11 April, the caseworker sent an email to the Deputy Head of the Women's Team as promised. She said that a transfer to Eastwood Park would enable the woman to have visits and asked whether she should talk to Eastwood Park. We have not seen a reply from the Deputy Head of the Women's Team but the same day the caseworker sent an email to a governor at Eastwood Park recommending the transfer to them and asking her to contact the Head of Offender Management. The governor sent an email to the Head about half an hour later asking her for information about the woman's record at New Hall and DPP paperwork. The Head was on leave and did not receive this email until her return to New Hall on 18 April. She told the investigators that she had left details of an alternative contact in her absence but it does not appear that this person was contacted.

177. At an ACCT review on 12 April, the woman admitted that she had been tying ligatures but releasing herself from them so as not to be caught with them. She said she was not always trying to kill herself when she did this but did not care if she died. There was no recorded discussion about her possible transfer to New Hall, which remained an incomplete action on her CAREMAP. She remained on ACCT observations once in every fifteen minute period. She spoke to her grandmother on the telephone at 8.00pm and seemed to be settled afterwards and chatted to the other women on Holly House about her life before she was in prison.
178. At 10.30am on 13 April, she was found with a tight ligature made from shoelaces around her neck. It was removed by two officers. She at first resisted their attempts to remove the shoelaces and would not tell them why she had tied it. At 2.00pm she had a long chat with an officer. She said she found it hard to trust people and got frustrated by situations she could not resolve. She said she felt that her solicitor kept "putting her off" when she called for information about the potential charges she faced from the fire setting on Poplar Unit. She was also worried about her grandmother's health and felt she was not receiving any information or help. The proposed video link call with her grandmother had not taken place because of security issues in the outside probation department. She said this was also a source of frustration to her. The officer said he would find out what was happening about the video link and talked to her about cognitive behaviour therapy (CBT) via one to one counselling with the psychiatrist or by access to literature. (CBT aims to help you to change the way that you think, feel and behave in order to cope with particular situations.)
179. The woman was also seen by a nurse. She told him that she had not planned the ligature and that her thoughts of self-harm were not always present as her mood was quite changeable. She had been thinking a lot about the past recently and unpleasant events that had occurred. She continued to worry about her grandmother and the charges relating to the fire setting. Her sleep was disturbed and she described her mood as five or six out of ten.
180. The Offender Supervisor went to see her in response to the concerns she had raised with the officer and nurse. The woman told her that she was worried about the charges she was facing for setting the fires in her cell. The Offender Supervisor told her that she would speak to the Head of Offender Management about her transfer to Eastwood Park and outside probation about the video link call to her grandmother. She promised to get back to her on Monday 18 April and an officer wrote in the ACCT record that she appeared happier after this discussion. The Offender Supervisor emailed the Head of Offender Management at 8.45am the next morning 14 April. She said she had visited the woman the day before and described her as "pretty down" after tying a ligature and making cuts to her neck. She asked for an update on her transfer.
181. On 14 April, the woman went to education in the morning and education and the gym in the afternoon. She was seen to be in good spirits and told an officer she was "shattered" after the gym. Another officer came on duty at 1.30pm that day. He said he remembered her laughing and joking with staff and prisoners at 5.00pm. A SO showed her a number of exercises and

everyone seemed to be in very good spirits. An officer also remembered her being in good spirits. In the evening, she came out of her cell for association and at 6.45pm she rang her grandmother. We have read the transcripts for all of the telephone calls she made in April 2011, and there is no obvious indication that she was particularly distressed or suicidal.

The events leading up to the woman's death

182. An officer was the 'late stay back officer' on Holly House. This meant he was the only officer on the unit between 7.30pm when day staff go off duty and 7.45pm when the night patrol OSG comes on duty. At interview the officer said that at about 7.45pm one of his last duties is to go round to each room and offer the women a light for their cigarettes. The women on Holly House are not allowed lighters in possession because previous residents had set fires. He remembered going to the woman's door to give her a light that night. She had several cigarettes already rolled in a cotton bud container and he told her that he wished all the women were as well prepared as she was. He said she had laughed with him about this.
183. When he got to another prisoner's room she said that the woman had told her earlier in the day that she had a ligature and was going to use it that night and pretend to be asleep. He returned to the unit office and wrote an entry in the wing observation book. He said he told the OSG to be extra vigilant with her and to ask for another OSG to be sent up to the unit if she felt concerned. No ACCT case review was held that evening following the information from the prisoner.
184. In a statement made to West Yorkshire police on 8 August, the prisoner said that the woman had been behaving differently on 14 April. She said she had not eaten which was unusual for her and had tied two ligatures during the day. The first one was removed by staff at about 10.00am to 10.30am and the second one during lunchtime (there was no evidence of this in the paperwork). She said the woman told her that she tied the ligatures because she had "too much stuff going on in her head". That evening she said the woman was upset and crying and told her she had argued with someone. She then told her that she wanted to kill herself and was going to tie herself up and pretend to be asleep to prevent the staff from checking her. She said she asked her not to tell staff. She said she was on her own with her between about 5.00pm and 7.00pm that evening and she talked about killing herself for "most of the time" but did not explain why she wanted to do it. She said that, once she was locked in her own cell at 7.00pm, she told the officer that the woman was not well and intended to kill herself.
185. At 7.30pm an OSG came on duty for the night shift on Holly House. The officer went through the list of women on the unit and told her about any issues she needed to be aware of. He told her that another prisoner had told him that the woman had a ligature. The OSG said she was made aware that she was on an open ACCT and she was required to check on her every 15 minutes. As was her practice the OSG then went to the door of each room and told the women that she was on duty that night and tried to have some conversation with them. The officer went off duty at about 7.55pm. He also did a final round of talking to every woman on Holly House. At interview he

said that there was nothing in the woman's behaviour to cause him any concern.

186. At 8.00pm the OSG made the first of her required ACCT checks on the woman and saw her sitting on her bed watching television. She said that she tried to draw her into conversation to try to find out if she had a ligature. She would not talk to her and only nodded when asked if she was alright.
187. The OSG checked on another prisoner who was also on an open ACCT and had a brief chat with the other prisoner. She decided to check on the woman again and returned to her cell at about 8.10pm. She looked through the main cell observation hatch and the small round observation which allowed her to see into the cell toilet area, but could not see her. She called her name but there was no response. She then went to the unit office, used the telephone to call the centre and asked for assistance from the night orderly officer. While she was waiting for them to arrive she went back to the room and shouted her name again. She broke the seal on her cell key pouch, in order to access the emergency cell key, and got the key ready to open the door immediately.
188. The OSG said that a SO and an officer arrived on Holly House within about 30 seconds. They called the woman's name and, when there was no reply, they entered the cell. The SO said she found her lying in the toilet area with a ligature around her neck tied to the hand rail. The OSG used her radio to request urgent medical assistance while the officer cut the ligature. As he did so he said that she appeared to exhale and he laid her head carefully on the floor. He then noticed that her bowels had emptied and she had a deep red laceration on her neck. The OSG waited outside the room to direct the nurses in. She said that they arrived about 30 seconds after the SO and the officer.
189. Nurse A was in the Primary Care room on Appletree House, another of the prison's units, with Nurse B and a Healthcare Support Worker (HCSW). They all went immediately to Holly House. The officer told them he thought the woman was still breathing. Both nurses felt for a pulse but could not find one. Nurse A then left the room to get oxygen from the unit treatment room next door to the woman's room. When she returned she asked the HCSW to collect an ambu-bag. (An ambu-bag is a hand held device made up of a bag and a breathing mask and is used to get oxygen into patients who have stopped breathing. The device can be used on its own or attached to an oxygen cylinder.) The SO used her radio to request an emergency ambulance.
190. Nurse B asked the members of staff to lift the woman on to the bed to make it easier to give her cardio-pulmonary resuscitation (CPR). She said the woman was sallow in complexion. She began chest compressions but found that she was wearing a bra. She told her that she was going to have to undo her bra because it was under-wired and they intended to use a defibrillator (a portable electronic device that detects activity in the heart and advises whether an electric shock is appropriate). She attached the defibrillator pads to her and it advised no shock but to carry on CPR. She found the ambu-bag was not working properly because the tube through which the oxygen needed to pass was sealed. The HCSW went to get another ambu-bag but she managed to get the original one working by breaking off the end of the tube. The nurses

and HCSW took it in turns to do chest compressions while two officers held the ambu-bag.

191. The first paramedic to arrive was a single first responder. In an emergency, the ambulance service sometimes sends a first response paramedic, who will be able to arrive more quickly than an ambulance. He took over and the nurses worked under his direction. The paramedic attached a defibrillator to the woman and also gave her two intravenous shots of adrenalin. Two other paramedics then arrived and all three worked on her before moving her to the ambulance and taking her to hospital. Two officers went with her in the ambulance.
192. One officer kept a log from the point at which she was told that she might be required to go out on an escort to hospital. She arrived on Holly House at 8.17pm as CPR was underway. At 8.40pm the paramedic first responder arrived on Holly followed quickly by an ambulance crew of two paramedics. The woman was moved to the ambulance at 8.53pm and the ambulance crew felt a pulse. The ambulance left the prison at 9.00pm and arrived at hospital at 9.15pm. An initial risk assessment for escort and bed watch was completed and it was decided that two staff should stay with her but that restraints should not be applied. (A risk assessment before transfer is completed to assess the level of risk that a prisoner might pose to members of the public when being transferred from the prison to hospital. The assessment caused no delay in the transfer of her.)
193. The wing observation book shows that the four other women on Holly House were spoken to at about 9.00pm that night. They did not ask any questions and all appeared to be OK.
194. The control room action checklist shows that the orderly officers were asked to go to Holly House at 8.10pm. An ambulance was requested and called at 8.15pm. The gate was told to prepare for the arrival of emergency vehicles at 8.16pm. The Governor was told what had happened at 9.10pm and came into the prison along with a SO from the staff care and welfare team. At 10.45pm the Governor led a hot debrief for the staff involved in finding the woman and trying to save her life. After any serious incident prison managers may hold a "hot debrief", which is a meeting of all the staff who were involved in the incident. The meeting focussed on reassurance, information sharing and how staff can support each other.
195. A governor contacted South Wales Police to request that the woman's family be told that she was in the intensive care unit at hospital. He gave the number of the hospital and a number for the family to ring if they wanted further information from the prison. The police visited the woman's grandmother at home at about 2.00am to break the news to her.
196. The Duty Governor completed escort and bed watch paperwork for staff with the woman at hospital. He decided that restraints were unnecessary and her family were able to visit whenever they wished. Escort staff rang the prison every hour to update them on her condition. The Roman Catholic Chaplain and a nurse visited her that afternoon. The escort staff were visited by a member of the care team.

197. The woman's family arrived at the hospital at 5.45pm. They spoke to escort staff and a member of the care team and stayed at her bedside. On 16 April, an officer was appointed as family liaison officer. He was on escort duty at the hospital at the time and had already spoken several times to the woman's mother. He was also on duty at the hospital on 17 April and was able to speak to the family again.
198. Sadly the woman's condition did not improve and life support treatment was withdrawn. She was pronounced dead shortly afterwards. New Hall activated their death in custody contingency plans and all relevant parties were informed.
199. The Governor issued notices to staff and prisoners. All prisoners who were on an open ACCT were reviewed. Listeners and Samaritans were made available to prisoners who needed support. The aforementioned prisoner was told personally of her death by an officer.

Family liaison after the woman's death

200. Two family liaison officers maintained regular contact with the woman's aunt in the weeks after her death. The prison offered financial assistance with the funeral but did not attend according to the wishes of the family. The Governor wrote a personal letter of condolence to the family on 20 April, and offered them the opportunity to visit the prison. The woman's aunt visited New Hall on 3 May. She visited Holly House, met two of her niece's friends and collected some of her property.

Staff support

201. All the staff interviewed reported that they had been well cared for and offered appropriate support following their involvement in the attempt to save the woman's life. We note that all of the women on Holly House were spoken to personally on the night of 14 April and that the aforementioned prisoner was told personally of her death.

ISSUES

The central register for women who cause disruption (DPP register)

202. According to the protocol, the aim of the DPP register is to:

“... ensure consistent, decent, honest, open and fair allocation of women whose behaviour causes disruption to the regime of an establishment ... It seeks to balance the needs of the individual women with the needs of the estate and provides the strategic overview to assist with ensuring a fair distribution amongst prisons reasonably able to manage and support them.”

The protocol gives the Women's Team responsibility for agreeing the transfers of women on the DPP register. Prison staff are required to create individual care management plans for each woman on the DPP, hold regular case conferences to monitor progress on these plans and to copy the minutes to the Women's Team. At the time of the investigation, there were 12 women on the DPP register.

203. There is no clear evidence as to how the woman came to be on the register originally or the reason for managing her in this way. The Women's Team were asked to account for the decision to put her on the DPP register and, in response, pointed to the criteria set out in their policy. However, they could not demonstrate the individual circumstances as they applied in her case because they held no records of any discussions in July 2009, which might have led to her being managed as a disruptive prisoner. The policy applies only to women over 18, yet she managed to be placed on the register just weeks after her 18th birthday.
204. There was no evidence of discussions between the Women's Team and Eastwood Park or Downview, about her transfers from each of those prisons. Therefore there is no evidence that her individual needs were considered at the time of either of those moves, or that her needs were balanced with the needs of the estate. The Women's Team could not demonstrate that either transfer was appropriately sanctioned by them in advance, in accordance with the requirements of the DPP.
205. We have seen little evidence that the woman was being managed according to the terms of the DPP register at Peterborough. An operational manager at Peterborough said that his recollection was that she was not on the DPP register when she arrived at Peterborough. Clearly someone at Peterborough was aware that she was on the register because someone provided the two (identical) reports to the bi-monthly Women's Team allocation meeting in July and September 2010. This is the only documentary evidence from Peterborough that we have seen relating to her management under the terms of the DPP. These reports were scant and did not reflect the number of incidents of self-harm or her repeated requests to move to Eastwood Park for

family visits. We have seen no care management plan required under the terms of the DPP or any subsequent case reviews to monitor this.

206. It is a concern that staff responsible for her daily management and management under ACCT were unaware that any transfer had to have the agreement of the Women's Team. They appear to have been aware that she was regarded as a disruptive prisoner but not how this affected her management and ability to move around the system. We do not know what happened to the number of applications made by the woman to transfer to Eastwood Park or have accumulated visits there or the outcome of attempts by staff to follow these up. According to her CAREMAPS, the onus for making the transfer happen was placed on her to improve her behaviour, put in applications and save her VO's. This is in itself a matter of concern. The reality is that any application she made and any chasing up of these by staff was rendered futile without the request being passed to the Women's Team.
207. The circumstances of her transfer from Peterborough are a major concern and had serious consequences. The transfer was agreed on the whim of a vulnerable and impulsive young woman just out of childhood without any proper consideration by staff at Peterborough about whether it was appropriate and in her best interests - irrespective of whether or not she was on the DPP register or subject to ACCT procedures.
208. The senior officer in Offender Categorisation and Allocations (OCA) at Peterborough, the department in a prison that decides and approves prisoner transfers, did not have a list of women at Peterborough on the DPP register. Therefore when she made the standard checks on the woman's record there was no overriding reason preventing her move to New Hall. This was another missed opportunity to alert staff to the need for approval from Women's Team.
209. The investigators met the Operational Manager on 13 July 2011, now Deputy Head of Men's Prison at Peterborough, who recognised that systems had broken down at the prison in November 2010 and the woman's transfer should not have taken place without the approval of the Women's Team. He said that, since her death had brought this to light, Peterborough had devised a new communication path with the Women's Team designed to prevent such errors happening again. We understand that the plan has been agreed by the Deputy Head of the Women's Team and covers information flow about women on the DPP register into and out of the prison. One of the changes made is that, as a failsafe, the SO in operations is provided with a list of the women at Peterborough on the DPP register.
210. When the woman was transferred out of Peterborough, it was again without the involvement of Women's Team. None of the required processes had been completed at Peterborough and therefore there was no effective transfer of information about risk and vulnerability to New Hall. As a consequence, none of the required documentation was completed at New Hall, although, unaccountably, an unsigned report was submitted to the Women's Team in November 2010 and a governor attended the Women's Team DPP allocations meeting that month.
211. The governor responsible for management of the women at New Hall on the DPP register said she was not aware until January 2011, (when she was

asked for an update for the January allocation meeting), that the woman was on the DPP register. She asked about a transfer on a number of occasions almost since her first arrival at New Hall, but it was not until March that the governor was asked to contact the Women's Team for their approval.

212. The whole sorry tale of the woman's transfer requests and the repeated failure to action them, calls into question the effectiveness of the DPP register and the role of the Women's Team in transfers. We have seen no evidence that the Women's Team were aware that she had been transferred from Eastwood Park to Downview, then to Peterborough, and eventually to New Hall without their sanction. Neither is there evidence that they were aware that Peterborough and New Hall were not completing the planning and review documents as required. Given their responsibilities and the vulnerability of women on the DPP register, this should have been recognised sooner. It is hard to understand the purpose of the Women's Team requiring regular update reports from prisons about individual women on the register if they do not notice reports are missing and do not know where the individual women are.
213. The Head of the Women's Team acknowledged to the investigators that a change of responsibility for the DPP register had contributed to a lack of proper vigilance over individual cases. She also commented, however, that a month was the usual amount of time it took to agree a transfer under the terms of the DPP register. In normal circumstances, we would agree that this would not amount to a terrible delay. However, the woman had been asking for a transfer for many months and unreasonable and insurmountable barriers had been put in her way.
214. We can understand the frustration of staff at New Hall at the perceived length of the process when they were dealing with an increasingly vulnerable young woman. To be asked for paperwork, from the Women's Team, which they had already explained they did not possess was doubtless extremely frustrating. In the woman's case, the month taken to agree the transfer came at the end of at least ten months of requests and applications from her to move to Eastwood Park. The problem lies not so much with what happened in the month after Women's Team were first contacted, but in what had not happened in at least the previous ten.
215. Once New Hall was properly aware of the woman's status and the correct procedure for transferring her, great efforts were made to ensure she moved to Eastwood Park. Nevertheless, the fact remains that all of the key players were not aware of this until mid-March, some four months after her arrival at New Hall. The situation is not one of individual error but of systemic failure. If only one part of the process breaks down the knock on effects could be crippling. In this case, it is apparent that all aspects that we have investigated failed. The Governor of New Hall recognised the usefulness of a central body ensuring the fair distribution of the most challenging women but said she was concerned that any register depersonalised the individuals on it. Information, even if provided regularly to a central body, can become quickly outdated – especially in view of the characteristics of the women on the register. In this case, a young and vulnerable woman was moved, following her challenge to staff, to a part of the country which meant she did not have a family visit for 16

months - clearly contrary to her needs and in clear breach of DPP and safer custody policies.

216. The day to day management and duty of care for individual prisoners lies properly with each establishment. The staff who work with prisoners daily have the most up to date knowledge of their issues and needs. We have seen no evidence in the woman's case that the involvement of Women's Team added sufficient value to her case management. Indeed, it can be argued that their intervention only served to add another layer of bureaucracy at a time when New Hall was concerned to affect an urgent transfer to Eastwood Park.
217. The Inspectorate of Prisons has been concerned about the operation of the DPP policy for some years. In their 2007/08 annual report the then Chief Inspector said:

"Some of the most challenging women in the prison system are being managed centrally by the Women and Young People's Group under the 'disruptive women's protocol'. In some cases, this means they spend months and even years in segregation. This is not only inappropriate but is also unlikely to help their psychological state or deal with fundamental problems. There is a need for a more positive and properly-resourced, policy for dealing with these women."

218. There is a need for appropriate resources and support to be given to women's prisons to help them manage some difficult and damaged women who are in need of effective intervention. However, the DPP process in this case focused too much on the symptom of the problem – the disruption – rather than dealing with its root causes. Ensuring that such women are 'fairly distributed' treats them as commodities rather than women with individual needs and often results in them simply being moved around women's prisons. The strategic oversight the register is supposed to bring was entirely missing. As a consequence of our findings we recommend that:

The National Offender Management Service should replace the existing register for women who cause disruption (the DPP register) with an effective and appropriately resourced strategy that focuses on dealing with the underlying reasons for the causes of the women's problematic behaviour and meets their individual needs.

The woman's transfer from Peterborough to New Hall on an open ACCT

219. Aside from the breakdown in systems at Peterborough, (and at Downview), that allowed the woman's status on the DPP register to be missed, we consider that there were other factors that should have prevented her transfer to New Hall happening at all or, at the least, so suddenly. She was on an open ACCT. Since her arrival at Peterborough she had spoken regularly about wanting to transfer to Eastwood Park – the only prison easily accessible to her family in South Wales - and she had never asked to transfer to New Hall. The SPCO on duty had led reviews on both the ACCT documents open in Peterborough. The other staff on duty knew her well and were familiar with her desire to move to Eastwood Park and her frustration at lack of visits from her family. They also recognised at the time that her request to move was

impulsive and said as a challenge to staff, "I'll bet you wouldn't send me". It was also recognised in reception that she might be regretting her request even before she left.

220. The woman's second ACCT at Peterborough was opened on 13 November, only five days before she moved to New Hall. She tied ligatures on 13, 14 and 16 November. On 14 November, she was reported to be happy and thought she would be transferred to Eastwood Park "soon". On 16 November, she said she was feeling emotional because her grandmother was not well. Her CAREMAP was updated to include the goal of "better contact with grandma", something unlikely to be aided by a transfer to West Yorkshire. On 17 November, the day before her move, she again asked to move to Eastwood Park to be nearer her family.
221. At the time of her transfer, instructions regarding the transfer of prisoners on open ACCTs were contained in chapter 15 of Prison Service Order (PSO) 2700 Suicide and Self-harm Prevention. Paragraphs 15.7.2 – 15.7.4 state:

"15.7.2 The intention to transfer a prisoner on an open ACCT Plan (or in the post-closure phase of ACCT) must be discussed with the receiving establishment, a record must be retained in the sending establishment to show this has been done (as well as a record made in the ACCT Plan), and relevant information must be conveyed either with or ahead of the prisoner. [Emphasis in original.] ... It is good practice to invite staff from the receiving establishment to attend a case review prior to any transfer of a prolific self-harmer.

"15.7.3 The proposed transfer, and issues arising from it, must be discussed at a case review with the prisoner ... [Emphasis in original.]

"15.7.4 The prisoner should be given information about the regime and facilities of the new establishment, helped to prepare, and subject to security considerations, be given the opportunity to contact family and friends before the transfer."

The first entry on her ACCT on 18 November is timed at 10.35am and was made by G4S escort staff (meaning she was on the escort vehicle). There was no record that New Hall was contacted or the transfer discussed with her, nor did a case review take place. Even without her status on the DPP register, she should not have been transferred without the provisions of PSO 2700 first being met. At the very least consideration should have been given to the circumstances in which she asked to transfer, the fact that New Hall was a significant distance from her home and the fact that she had repeatedly expressed a desire to move to Eastwood Park to facilitate visits from her family.

The Director of Peterborough should ensure that reception staff, the OCA department and unit SPCOs are aware that prisoners on open ACCTs should not be transferred without following the guidance in chapter five of PSI 64/2011.

Managing the woman's needs

Enhanced Case Reviews

222. For a significant proportion of the woman's time in custody she was on open ACCTs, self-harmed by cutting and tied several ligatures. She was described as disruptive, and was managed on the basic regime and given cellular confinement. She also set fire to her cell in March 2011, after which she was dressed in anti-ligature clothing intermittently for over two weeks.
223. According to Chapter 9 of PSO 2700 (in force at the time of her death), "Managing at-risk prisoners whose behaviour is particularly challenging", she should have been managed under the enhanced case review process. This additional safeguard is designed to support prisoners who are sustained self-harmers and are disruptive of the regime. The PSO made it mandatory for prisoners whose self harm involved fire-setting or who were subject to measures of last resort to be managed under the enhanced case review process. (Anti-ligature clothing is identified as a 'measure of last resort' in the PSO.) She fulfilled both of these criteria, but her ACCT was never escalated to the enhanced level of care. In addition, her status on the DPP register indicated that she was regarded as a prisoner whose 'behaviour was particularly challenging'.
224. The woman's self-harm was managed using standard ACCT procedures. Behaviour that was classified as "disruptive" was managed separately under the IEPS scheme. She was often managed on the basic level and as a consequence of her more aggressive behaviour was given periods of cellular confinement, despite her identified risk of self-harm. The management of each aspect of her behaviour inevitably had an impact on her, nevertheless her self-harm and disruptive behaviour were managed separately.
225. In order to deal with disruptive and challenging prisoners, staff need to make a full and proper assessment of all aspects of their behaviour and all its causes. In her case, she repeatedly told staff that she wanted to move closer to her family. It is easy to label prisoners like her as disruptive, but once given this label it can be very difficult to remove. As a consequence it is the behaviour that then becomes the problem and the focus of staff's attention. One of the possible identified root causes of her behaviour, contact with her family, was then often considered a secondary issue. There was no holistic consideration at a multi-disciplinary forum of the range of her behaviour and what it might mean.
226. The enhanced case review process is outlined in PSO 2700:
- "Individuals who present with a combination of self-harming and very violent behaviour should be managed pro-actively on long-term, multi-disciplinary ACCT care plans by an enhanced case review team ... Consistent, integrated care by all staff involved with the prisoner is critical, and the case review will need to ensure care planning enables staff to provide this. As well as setting out the normal planning expected in a CAREMAP, e.g. location, regime, specialist interventions, frequency of conversation and observation, any items not allowed in use, *it must also include a named key worker(s), strategies*

for encouraging pro-social behaviour, and agreed strategies for responding to each individual problem behaviour that the prisoner displays: both those behaviours that involve self-harm and those that involve anti-social behaviour.”

227. The woman should have been managed under the enhanced case review system. Had enhanced case reviews been held in accordance with the procedures in the PSO, her behaviour would have been considered in the round, rather than dealt with according to the prison policy or procedure that they were thought to fit into. Senior staff would have been involved in the care plans. Her self-harming and disruptive behaviour would have been discussed by a multi-disciplinary review team and a long term care plan, taking into account all aspects of her behaviour, could have been put into place. We therefore make the following recommendation:

The Governor of New Hall should ensure that enhanced case reviews are held in accordance with the requirements of PSI 64/2011.

ACCT CAREMAPs

228. The woman asked various members of staff about a transfer or accumulated visits on 22, 25, 26, 28 and 29 January, 5, 15 and 16 February. On 11 March, the goal of a transfer to Peterborough, rather than Eastwood Park, was added to her CAREMAP. On all of these occasions she was informed that either her behaviour needed to improve or her ACCT needed to be closed before a transfer was possible. Irrespective of the obstacles later placed in the way of a transfer by her inclusion on the DPP register, this approach severely limited her chance of achieving a transfer and added to her distress. By making her transfer conditional on her reducing her self-harm (and by extension being removed from ACCT) the concentration was on trying to remove the symptoms and not treating the underlying cause of her behaviour. Her distress about her lack of family visits and the frustration of her situation appeared to exacerbate her self-harm. Prolonging her lack of visits by further postponing the possibility of a transfer did little to help her.
229. We are concerned that responsibility for achieving the goals set on the CAREMAP was too often given to her. It is important for the person on the ACCT to be given some responsibility for improving their situation. However, it was not appropriate for the goal of completing a transfer request to be described as her responsibility on her CAREMAP, as it was on a number of occasions. Too often the onus to achieve the outcome was placed on a vulnerable young woman who had no power to secure a transfer, rather than prison staff who could. The goal would have been more achievable had a named member of staff also been involved to help.
230. CAREMAPs were rarely updated, and there were often outstanding actions when the ACCT document was closed. PSO 2700 required that all actions on a CAREMAP were completed before an ACCT could be closed, and that there should be management checks to ensure this was the case. Had the mandatory checks taken place, the woman's request to transfer might have been dealt with sooner than it was.

The Governor of New Hall should ensure that CAREMAPS address the cause of the individual's distress, that realistic goals are set, and that responsibility for achieving goals is balanced between the individual and named members of staff, following the guidance in PSI 64/2011.

ACCT case reviews

231. The woman's numerous ACCT case reviews were not multi-disciplinary, and she did not attend many of them. Despite her resistance, we are satisfied that frequent attempts were made to encourage her to be involved with the ACCT process.
232. She had a long history of tying ligatures. On every previous occasion, apart from a single incident 20 December (when she attached the material to pipes in her cell) she wound material around her neck. She either alerted staff or was found promptly and the ligatures removed. The ligatures were almost always loose and no significant injury was recorded on any of the previous occasions. On 7 April, she admitted to tying the ligatures with increasing tightness. She was found with a tight ligature made from shoelaces on 13 April. This was however, a recent departure. ACCT case reviews were held following most of these episodes, although there were some occasions when no case review was held. According to section 3.3.2 of PSO 2700, all episodes of self-harm should prompt a case review. We therefore make the following recommendation:

The Governor of New Hall should ensure that an ACCT review is undertaken after any act of self-harm.

233. At about 7.45pm on 14 April, a prisoner told an officer shortly before he went off duty that the woman had a ligature and was intending to use it and pretend to be asleep so that staff did not discover her intentions. The officer did not question her about this or seek to enter her cell to search for a ligature. He said he told the OSG to be extra vigilant and ask for the night orderly officer to come over if she was concerned. He also wrote a note of the incident in the Holly House observation book.
234. At interview, the officer explained that he would always pass on such information to incoming staff. In this case he decided not to take further action for two reasons. Firstly, the woman had been in good spirits all afternoon and had laughed with him when he gave her a light just before the prisoner spoke to him. He had checked her every 15 minutes during the evening duty and had seen no evidence that she was preparing to harm herself. Secondly, he did not regard the prisoner as a reliable source of information. He described her as attention-seeking and liable to say things in order to provoke a reaction.
235. Given the woman's improved demeanour, the officer took what he considered to be appropriate action. He passed the information onto the OSG taking over from him and he wrote in the wing observation book. However, he did not speak to the woman about his conversation with the prisoner or make an entry in her ACCT document. Following her handover from the officer, the

OSG tried to draw the woman into conversation in her first ACCT check of the shift, but she refused to engage.

236. Following his conversation with the prisoner, the officer was not strictly required by the PSO to hold an ACCT case review because it was an allegation that the woman was going to harm herself, and not actually self-harm. Nevertheless, he should have made an entry in her ACCT about that conversation and recorded whether he had considered holding an ACCT case review. We also believe that, in the light of the information he should personally have spoken to her to ask whether she had a ligature and considered whether any further action was needed. We therefore make the following recommendation:

The Governor of New Hall should ensure that whenever any information is received suggesting a woman on an open ACCT is intending to harm herself, full consideration of the options and action taken is recorded in the ACCT documentation.

The woman's IEPS status and cellular confinement

237. The woman was managed on the basic regime as a result of her disruptive behaviour. Despite this, she appeared to be in regular telephone and letter contact with home. A SO told the investigators at interview that, because staff on Poplar Unit were aware that she was a long way from home and missed her family, they sometimes allowed her extra telephone calls from the wing office if her credit was low.
238. However, her placement on basic did affect her frequent requests for a transfer closer to home. As noted in this report, she was told often that her behaviour needed to improve before another prison would accept her. Again this approach focussed on the symptoms rather than the cause of her behaviour. The strict application of IEPS, and restrictions of cellular confinement, was unlikely to produce better behaviour from her while the prospect of a transfer seemed remote. This effectively locked her in a repeating pattern – she was upset about her lack of visits, her behaviour was poor, she was placed on basic and told she needed to improve before a transfer was possible. She therefore remained frustrated and her behaviour continued to be poor, which in turn led her to carry out acts which led to her cellular confinement and so the cycle continued. This approach lost sight of the real issue that a vulnerable 19 year old remained without a family visit for a considerable length of time.
239. PSO 2700 strongly discouraged the use of cellular confinement for prisoners who were managed under the ACCT process:

“Prisoners on an open ACCT Plan or in the post-closure phase of ACCT (i.e. the ACCT Plan has been closed, but the final post-closure review has not been signed off) must not be managed in accommodation (such as a Segregation Unit or special accommodation) that reduces their access to social support, other people, activities and stimulation unless, exceptionally, they are such a risk to others that no other suitable location is appropriate and where

all other options have been tried or are considered inappropriate.”

240. In the absence of the enhanced case reviews, there was no evidence that consideration was given to alternative accommodation. The PSO required that the decision to give prisoners cellular confinement when they were on an ACCT had to be authorised by the Duty Governor, who had to make a corresponding entry in the ACCT document. There was no evidence of the Duty Governor’s authorisation when the woman was given cellular confinement, nor was there an entry from the Duty Governor in her ACCT document on those occasions. We therefore make the following recommendation:

The Governor of New Hall should ensure that prisoners on open ACCTs are segregated only in exceptional circumstances, with the authorisation of the Duty Governor.

The woman’s fire setting

241. The woman had warned staff in a note she wrote in February that she had thoughts of setting fire to herself as a means of self-harm. She was relocated to Holly House after she set the fires in her cell on 11 March. She told staff that she wanted to move closer to her friend in Sycamore House, but she also told the psychiatrist that she intended to kill herself. This incident came two days after she was removed from workshop and a day after she had made cuts to her arm and neck. The cuts to her neck were a new departure for her and she told staff that it had scared her. Additionally she warned staff that she had thoughts of setting fire to herself just over two weeks before she did so.
242. The fire setting was a serious incident which could have resulted in serious injury to both the woman, other prisoners and staff. She was charged with breaking Prison Rules, by setting the fire in her cell, and the following day the matter was referred to the police. We understand that the policy at New Hall is that all incidents of arson are reported to the police in line with PSO 3803, Fire Safety, Annex A, which states that, “*where arson is suspected fires must be reported to the Police*”.
243. However, Prison Service Order 2000, The Prison Discipline Manual, Adjudications, Annex C, Criminal Offences in Prison Service Establishments, C20, which was in operation at the time the woman set the fire, stated that:
- “... Governors or Directors will wish to be particularly aware of the possibility that cell fires may in fact be evidence of a prisoner’s highly disturbed or suicidal state of mind. Acts that amount in reality to attempts at self-injury should **not** normally be referred, nor dealt with under the internal disciplinary system.”
244. Guidance in PSI 47/2011 – Prisoner Discipline Procedures which is the current instruction also says that it would not normally be appropriate to lay disciplinary charges where the prisoner’s actions were related to self harm but indicates they should be where the act endangers others’ health and safety. There is a lack of clarity about the circumstances in which charges should be referred to the police in the PSI with no reference to possible self harm issues.

In any event New Hall followed the guidance in PSO 3803 which they believed made it mandatory to refer such charges.

245. At the woman's case review conducted after the fire, which she did not attend, staff noted "... that her impulsive behaviour may lead to further attempts of suicide or self harm." As a consequence her observations were increased to four an hour, she was given anti-ligature clothing and she was placed in a camera cell. Despite apparently recognising and managing the fire setting as part of her escalating pattern of self harm, her actions were reported to the police as suspected arson. The adjudication papers just record that the charge was referred to the police with no reasons given.
246. When told that the matter had been reported to the police she became concerned that she would be charged for committing arson, with the possibility of an indeterminate sentence. Staff noticed that she became more stressed after this, and the prospect of an additional charge clearly heightened her overall anxiety. In light of her history and escalating self harm at the time, we do not consider it was appropriate for the incident to be referred to the police which served only to increase the anxiety of an already vulnerable young woman and potentially undermined the support measures put in place to manage her risk.

The Chief of Executive of NOMS should clarify the guidance to prisons for referring charges involving fire setting to the police. Decisions should take into account all the history and circumstances and the reasons for referrals should be fully documented.

The woman's care on Holly House

247. The woman was located on Holly House after she had set the fire because staff felt she needed additional support. There are more officers on Holly House, all of whom are selected to work on the unit and receive mental health training. A SO and the other staff felt that they could work with her positively. We consider that this was a reasonable decision in the circumstances.
248. Indeed after an initial period of unhappy behaviour she appears to have responded well on Holly House. There are an unprecedented number of positive comments on her record for this period compared to her time on Poplar Unit. Staff had cause to think they were making real progress with her. Once on Holly House, the SO realised that the presence of mental health staff at ACCT reviews was stopping her talking freely. She decided to separate the two processes and this resulted in her engaging much more with staff and talking more fully than ever before about her issues. During April she engaged with the mental health team for the first time ever in prison.
249. The clinical reviewer addresses the issue of the woman's treatment on Holly House and whether she would have been more appropriately cared for in a secure mental hospital. He says:

"It is clear from the records and interviews with staff that she was an impulsive young woman who had difficulty in communicating her problems. In my view, mental health staff at New Hall were very assertive at engaging with her and had a clear long term plan in place

with her involvement. There is also evidence of close working with prison officers on Holly House who also worked hard to engage her. She was prescribed appropriate medication which was well monitored.”

The woman’s location in cell H2-05

250. The woman was moved to the cell used for disabled prisoners (H2-05) in recognition of her progress on Holly House. It was a bigger, lighter, warmer cell, close to the staff office and with a view of the gardens. At interview a SO said that a previous prisoner had attempted to suspend herself from the window of the cell and as a result a sheet of Perspex had been placed over the window surround. A health and safety check had been done after this incident but inexplicably this had not identified the hand rail in the toilet as a potential ligature point. The SO said that after her death it was immediately realised by staff that the hand rail in the toilet should not have been there. The SO said she was not aware that the hand rail was there when she was put into the cell but remembered that the Perspex had been put up. The investigators were told in their initial meeting with the Governor that since her death the hand rail in the toilet area of the cell to which she tied the ligature on 14 April, had been removed.
251. 14 April was not the first time she had tied a ligature in that cell and she had not previously used the hand rail or anything else to secure those ligatures. We do not criticise the use of cell H2-05 for her as it was not intended to be a ‘safer cell’ with minimal ligature points. She was not regarded as such a high risk at that time as to have required a safer cell. In addition to the hand rail there were many other ligature points which could have been used. If there is to be any criticism of the cell, it does not relate to its use for her, but to the earlier decision to cover the window bars. This could have led to a false sense of security, for the previous occupant, that the cell was a safer environment than others.
252. For the woman, the disabled cell was considered to be a better environment, therefore a progressive move. Staff thought it was in her interest to remain on Holly House, where she seemed to have settled. None of the cells on Holly House were safer cells and at that point in time staff did not believe she required a safer cell. We are satisfied that this was an appropriate location given the information available to staff at the time.

Staffing levels on Holly House

253. At interview, several staff from Holly House raised the issue of the staffing level of mental health staff on Holly House. Up until December 2010, 24 hour cover was provided by a Registered Mental Nurse (RMN). When the contract changed in January 2011, the number of hours was reduced to Monday to Friday between 8.00am and 4.30pm. This was intended to provide that a greater concentration of support during the day when it would be of more benefit. During the day nurses have free access to work with the women on Holly House, whereas overnight they would only be able to speak to the women through the door. By April 2011, the day time cover had been extended so that additionally one RMN arrived at 7.30am and a one RMN stayed in the prison until 7.00pm Monday – Friday. This was to improve

continuity between night staff and day staff and to cover late receptions and medication. General nursing cover is still provided 24 hours a day.

254. Many staff expressed anxiety that officers, not healthcare staff, had too much responsibility for the care of the most severely mentally ill and vulnerable women in New Hall. Staff were particularly concerned about the night time arrangements when responsibility for these women passed to a single operational support grade (although in January 2011 the Governor decided that the OSG assigned to the gate area would be redeployed to Holly House after 10.00pm to provide extra support). Staff told the investigators that the theory that there was more input from mental health nurses during the day did not work so well in practice because they were often required to be in other parts of the prison.
255. This issue was raised by the Prison Officers' Association at meetings with senior management in January, February and March 2011. A request for the night emergency response nurse to be based in Holly House did not find favour with healthcare staff.
256. We asked the clinical reviewer to address this issue in his review. Although the clinical reviewer notes that general nursing staff felt that an extra burden had been placed on them to provide seven day 24 hour cover, he concluded:

“Holly House has the advantage of a higher prison officer ratio being only twelve beds. The newly developed mental health service allows for intensive targeted support at the loss of 24 hour RMN cover. In my view that is a good use of limited psychiatric resources and a clear stepped approach based on need is in place which equates to current practice outside prison. There is not in my opinion a causal link to this death and the removal of 24 hour RMN cover.’

257. At interview, the OSG said that there was normally a dedicated OSG on Holly House at night but at the time the woman died this person was on long term sick leave. The investigators were not given any examples of occasions on which it would have been of benefit to have had an RMN on duty at night. We agree with the clinical reviewer that staffing levels were not an issue in the events of 14 April. The investigators discussed the matter with the Governor and it is difficult to make a case on the evidence for recommending that overnight cover is increased. The Governor has responded to staff concerns by deploying a second OSG to Holly House from 10.00pm. In the circumstances we think it makes sense that:

The Governor should ensure that, where possible, consistent and appropriately trained staff are detailed to work on Holly House at night to allow them to build up trust and knowledge of the residents.

The prison's response to finding the woman unconscious on 14 April

258. In accordance with the number of checks prescribed by the woman's ACCT document, the OSG checked her at 8.00pm and then again at 8.10pm. She was watching TV at 8.00pm but could not be seen and did not respond at 8.10pm. She called for assistance and returned to the cell, tried again to raise her and broke the seal on her key pouch to be ready to enter the cell upon

arrival of the other officers. She could not see her and did not know what situation she was facing. New Hall's instructions for entering a cell during the night require that where there appears to be an immediate danger to life cells may be unlocked by one member of staff if safe to do so, following a dynamic risk assessment of the situation.

259. The OSG told the investigators that she has been told not to enter cells on her own. In this instance she might well have assessed that it was not safe to open the cell, given that the woman could not be seen and therefore it was not clear that she was in need of emergency medical help. However, we are concerned that she was under the impression that she could not enter a cell on her own at night in any situation, and no dynamic risk assessment was made. We make the following recommendation:

The Governor should ensure all staff working nights are aware of New Hall's contingency plans for entering a cell at night if there appears to be an immediate danger to life.

260. A SO and an officer arrived at the cell very quickly and entered without delay. Emergency medical help was called for and the nurses arrived within a few seconds. They were in close proximity to the cell and had no locked doors in their way. Two nurses felt for a pulse and could not find one. They both remarked at interview that the woman looked 'sallow' and in need of oxygen. Nurse A went next door to get some oxygen and Nurse B told staff to lift her on to the bed. At interview she explained that there was too little room on the floor of the toilet to undertake CPR effectively and the bed was a hospital bed and therefore firm and height adjustable.

261. The Working Group of the Resuscitation Council (UK) provides guidance for safer handling during resuscitation in healthcare settings:

"If a patient is collapsed on the floor, CPR should be carried out on the floor. Start CPR as quickly as possible and try to provide the best quality CPR, particularly chest compressions, that is possible in the circumstances. Do not move the patient unless there is inherent danger to the patient or rescuers in that location.

If access to the patient is restricted, where possible, move the furniture. If it cannot be moved quickly and safely it may be necessary to slide the patient horizontally across the floor to an area that is less restricted ... Poor access to the patient may result in the rescuers having to twist and bend awkwardly and this may impair the quality of CPR or risk potential injury to the rescuer."

The guidance also advises that rescuers must have enough space to apply force vertically down from their shoulders to make compressions more effective. There should also be sufficient space around the patient for the rescuers to manage the patient's airway effectively. The guidance says that manual lifts from the floor, especially in confined areas, are high risk and for resuscitation to be effective, a firm surface is required underneath the patient.

262. At interview the nurse explained her reasons for asking staff to lift the woman from the floor of her toilet area to her bed. She said that there was no room in

the toilet area to work on her effectively. The bed was a hospital bed that had a firm mattress and was height adjustable and had a removable back. This made it easier for the nurses to administer CPR and set up and administer oxygen.

263. In the light of the Resuscitation Council (UK) Guidance, it does not seem to have been appropriate to have moved the woman from the floor to the bed. A strict interpretation of the guidance would probably mean that she should have been slid across the floor to a bigger space rather than risking lifting her. Best practice is that patients found on the floor should remain on the floor. The clinical reviewer examined the bed and described it as a solid hospital bed with a firm mattress on a solid base and “ideal for resuscitation”. Resuscitations routinely take place on beds in hospitals and in the circumstances he considered that the nurse’s decision was reasonable.
264. However, it is a matter of concern that the guidance issued by the Resuscitation Council in relation to moving the patient was not followed. It is not clear that the “high risk” associated with lifting a patient described in the guidance was sufficiently taken into consideration. Nevertheless, we recognise that the surface was appropriate, that CPR began promptly and that the woman’s heart was successfully restarted after considerable work by staff and paramedics. In her case therefore, the movement seems to have had no detrimental effect. Nevertheless, we make the following recommendation:

The Healthcare Manager should ensure that CPR is started where the patient is found unless there is an inherent danger in doing so, in accordance with the Resuscitation Council (UK) guidelines.

265. The clinical reviewer addresses the issue of the blocked tube on the ambu-bag in his report. The blockage was removed quickly by snapping off the end of the tube and did not delay resuscitation significantly. However, he notes that the Medicines and Healthcare Products Regulatory Agency (MHRA) defines this as an adverse incident (an event that causes or has the potential to cause unexpected or unwanted effects involving the safety of device users including patients). The MHRA requires that an adverse incident form be completed and the faulty equipment quarantined. In this case the incident form was filled out but the equipment was thrown away. He makes the following recommendation which we endorse:

The Healthcare Manager should ensure that the management of and training about adverse incidents involving medical equipment should be reviewed so that staff are aware of the latest guidance.

266. He makes three further recommendations about the mental health on-call system because there was a delay in responding to the prison to a call made after the woman had been taken to hospital. We have not repeated them here but they can be seen in his report, together with NHS Wakefield and District’s response.

Issues raised by the woman’s family

267. The family asked, in the light of her two previous suicide attempts at New Hall, what psychiatric or medical assessments the woman had and whether she

was referred for mental health treatment.

The investigation found that mental health staff actively attempted to engage with her from her arrival in November 2010 and after every incident of self harm. She consistently refused to engage until on 25 February 2011, she agreed to be assessed after speaking to a SO. She clearly felt uncomfortable opening up to staff, especially mental health staff, and records show that she often refused to speak to them. Once she moved to Holly House on 11 March, the situation improved. She talked more freely to a particular nurse and saw the prison psychiatrist in March and April. The clinical reviewer has commented very favourably about her mental health treatment on Holly House in his clinical review, but unfortunately her engagement with mental health service had only just begun.

268. The family asked why they were not told about the two attempts on her life that she made at New Hall.

PSO 2700 Suicide and Self Harm Prevention and PSO 4800 on Women Prisoners both encourage staff to try to involve families in dealing with prisoners who regularly self harm. Before doing this consent must be given by the prisoner. It was recorded at the beginning of each of her ACCT documents that she did not give permission for her next of kin to be contacted in connection with her risk of self harm. However, there was no recorded discussion in her last ACCT that staff spoke to her about it after that first refusal. Despite the lack of records to confirm it, staff assured the investigators that she categorically refused to give her consent to staff contacting her family about her self harm, not wanting her grandmother to be worried. Staff said that they tried to persuade her on a number of occasions that her family could be a useful source of support, but she did not want them to be contacted. These discussions should have been recorded in her ACCT. She remained reluctant to talk to anyone about her self harm and records show that she often attempted to hide her attempts from them. The nurse had some difficulty in gaining her agreement to him telephoning her grandmother. This is the only occasion we have found when she agreed to a member of staff contacting her family.

269. The family asked why she was in a cell by herself, given her state of mind, and what the thinking was behind this decision.

All of the cells on Holly House are single occupancy. Because of the criteria for women on Holly House many of the women there are regarded as unsuited to sharing with other prisoners. As discussed at paragraph 243, we consider that her location on Holly House was appropriate to her needs.

270. The family wanted to know why she was moved to Holly House, which was away from two of her closest friends and might have heightened her feelings of isolation.

She was moved to Holly House after she set the two cell fires on 11 March. However, it was decided to keep her on Holly House because staff felt they could work with her and in an attempt to encourage her to engage with mental health staff. Holly House typically houses only a handful of women and the staff/prisoner ratio is high. Staff employed there have to demonstrate a desire

to work with the most challenging prisoners. She appears to have been unhappy with her location there at first, but then she began to interact with staff and mixed well with the other women. She appeared to become generally more stable during her time on Holly House before her death.

271. The family asked about the timings of her suicide observations and whether they were made correctly.

The timings of her ACCT checks are detailed throughout the report. With one very brief exception, on 7 April, when the paperwork suggests that observations remained once in every hour when a decision had been taken to increase them to once in every 15 minutes, we have seen no evidence to suggest that ACCT checks were not carried out when they should have been. We also consider that there are many examples of high quality entries on the ACCT documents.

272. The family wanted to know why she was transferred to New Hall because this made it almost impossible for the family to visit her.

This is dealt with at length in the report.

273. The family wanted to know whether she had been bullied or victimised by staff at New Hall.

The investigators saw no evidence that she was bullied or victimised by staff. The overwhelming impression they received was that, despite her often challenging behaviour, she was thought of fondly by the staff interviewed.

274. The family wanted to know why, following the previous attempts that she had made on her own life, she was put in a cell with an obvious ligature point, namely a hand rail.

This is dealt with at paragraphs 246 to 248 above.

CONCLUSION

275. The woman was a young woman who had spent most of her adolescent and teenage years in the criminal justice system. She had a long history of self-harm, her behaviour was challenging to staff as she could be both verbally and physically abusive. However, she was also a very vulnerable young woman. She was frequently moved between different women's prisons, and although her overriding and continuing concern was to receive visits from her family, eventually she went to New Hall in Yorkshire, a considerable distance from her home in South Wales.
276. Nevertheless, the investigation into her death has established that staff at New Hall deserve some credit for their management of her. Despite some setbacks, she appeared to have been more settled and had begun to open up more to prison staff. Examples of this were her confidence to discuss in depth her inner feelings with officers and her engagement for the first time with mental health staff. But there was no overarching case management plan or enhanced case reviews in place for her and it sometimes appeared as if some of the prison processes were in conflict with each other. For example, she was subject to the basic regime and punishments of cellular confinement at the same time as she was supposed to be cared for as at risk of suicide and self harm. We note that this was a general problem the Inspectorate identified in its 2008 inspection. She set fire to her cell which was managed as a serious act of self-harm, yet was still referred to the police and caused her additional anxiety.
277. The woman's case evidences a catalogue of failures to address her needs as a particularly vulnerable and challenging young woman. Peterborough failed to arrange a transfer to Eastwood Park and allowed her to move to New Hall when this was not in her best interests, contrary to established procedures for women on the DPP register and women on open ACCT documents. This left her even further from her home area and family, which throughout her time in custody was significant source of distress. Initially at New Hall, her needs were inadequately addressed, until it was recognised that she was on the DPP register and the prison contacted the national Women's Team in an effort to break the cycle of her self harm by arranging a transfer. Throughout, the Women's Team failed in its duty adequately to monitor and oversee her overall progress and care, in line with the procedures on the protocol which they had devised. It is a dreadful irony that, in the end, it was that protocol which hampered her move back to a prison where she might have had the opportunity to see her family.

RECOMMENDATIONS

1. The National Offender Management Service should replace the existing register for women who cause disruption (the DPP register) with an effective and appropriately resourced strategy that focuses on dealing with the underlying reasons for the causes of the women's problematic behaviour and meets their individual needs.

Accepted - Women & Equalities Group in NOMS is undertaking developmental work, dependant on available resources, to introduce a Central Case Management Unit for women with the most complex needs. This will replace the current DPP register. The women identified will have individual case plans tailored to their needs and the Unit will ensure that the women are accommodated in prisons which are best able to meet their needs. It is envisaged that the proposed model will have expert clinical input and be closely aligned to the NOMS PD Strategy.

2. The Director of Peterborough should ensure that reception staff, the OCA department and unit SPCOs are aware that prisoners on open ACCTs should not be transferred without following the guidance in chapter five of PSI 64/2011.

Accepted - All staff will be made aware of the requirements of PSI 64/2011 through a Staff Information Notice and via staff briefings.

3. The Governor of New Hall should ensure that enhanced case reviews are held in accordance with the requirements of PSI 64/2011.

Accepted - Guidance to be issued (Governors order) to ensure Operational managers, Senior Officers, Offender Supervisors, & MHIR staff. Identify the need to consider enhanced case management referral if the criterion within PSI64/2011 is met.

Also review of current SMT & unit manager ACCT management checks to be undertaken to ensure any non compliance is identified.

4. The Governor of New Hall should ensure that CAREMAPS address the cause of the individual's distress, that realistic goals are set, and that responsibility for achieving goals is balanced between the individual and named members of staff, following the guidance in PSI 64/2011.

Accepted - Guidance to be issued (Governors order).

Refresher training for case managers in the quality completion of the *CAREMAP ensuring that it reflects the prisoner's needs, level of risk, and the triggers of their distress. Also highlight the need to try to address the issues identified in the ACCT assessment interview.*

Also review of current SMT & unit manager ACCT management checks to be undertaken to ensure any non compliance is identified. *The new training (introduction to Safer custody) package to be delivered to case managers. Giving*

particular emphasis on Care mapping.

5. The Governor of New Hall should ensure that an ACCT review is undertaken after any act of self-harm.

Accepted - Guidance to be re-issued (Governors order) highlighting the mandatory need to ensure that an ACCT review is undertaken after any act of self-harm is identified.

Also review of current SMT & unit manager ACCT management checks to be undertaken to ensure any non compliance is identified.

6. The Governor of New Hall should ensure that whenever any information is received suggesting a woman on an open ACCT is intending to harm herself, full consideration of the options and action taken is recorded in the ACCT documentation.

Accepted - Guidance to be issued (Governors order).

Refresher training for all staff in the quality completion of ACCT documentation.

Also review of current SMT & unit manager ACCT management checks to be undertaken to ensure any non compliance is identified.

7. The Governor of New Hall should ensure that prisoners on open ACCTs are segregated only in exceptional circumstances, with the authorisation of the Duty Governor.

Accepted - Guidance to be reissued (Governors order).

Refresher training for Operational Managers in the need to fully document ACCT documents, for prisoners who after all other consideration & in exceptional circumstances, segregation is authorised.

8. The Chief of Executive of NOMS should clarify the guidance to prisons for referring charges involving fire setting to the police. Decisions should take into account all the history and circumstances and the reasons for referrals should be fully documented.

Accepted - NOMS intends to publish a PSI on the reporting of all crimes to the police, including arson, and it will be circulated to the Ombudsman and others for comment during the autumn with the intent of publishing at the end of the year.

9. The Governor should ensure that, where possible, consistent and appropriately trained staff are detailed to work on Holly House at night to allow them to build up trust and knowledge of the residents.

Accepted - There will be a dedicated night team detailed to Holly House. The integrated mental health team will support the training of night OSGs based on Holly House to enhance their understanding of mental illness through mental health awareness sessions.

10. The Governor should ensure all staff working nights are aware of New Hall's contingency plans for entering a cell at night if there appears to be an immediate danger to life.

Accepted - The night operating procedures and contingency plans for nights will be reviewed. Any amendments that need to be made to ensure staff are aware of the need to enter cells in circumstances where there is (or appears to be) an immediate danger to life will be made and the changes communicated to the appropriate staff.

11. The Healthcare Manager should ensure that CPR is started where the patient is found unless there is an inherent danger in doing so, in accordance with the Resuscitation Council (UK) guidelines.

Accepted - All staff within the integrated mental health team have completed Basic Life Support training and are aware their responsibilities in the event of a cardiac arrest.

Hotel 1 is the emergency radio that is always carried by a qualified member of Spectrum Healthcare staff. It is expected that any call will receive an immediate response. CPR training is given to all of Spectrums staff annually. It is expected that CPR is initiated unless as you have stated that there is inherent danger or where life extinct is obvious with the signs of Rigor Mortis.(supported by Resuscitation Policy)

12. The Healthcare Manager should ensure that the management of and training about adverse incidents involving medical equipment should be reviewed so that staff are aware of the latest guidance.

Accepted - Nottinghamshire Healthcare offender Health has an electronic medical devices alert system to advise of alerts and request action where necessary. Emergency response equipment is managed by our counterparts Spectrum with whom we share training needs via our joint Clinical Governance forum.

As stated above Spectrum has a central alerting service that informs of any concerns re medical devices.

Emergency equipment is checked on a weekly basis by nursing staff and annually by the Medical devices dept at Mid Yorkshire Hospitals.