



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a woman at HMP
Downview in July 2013**

Our Vision

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

This is the investigation report into the death of a woman, who was found hanging in her cell at HMP Downview in July 2013. She was 41 years old. I offer my condolences to her family and friends.

A clinical reviewer reviewed the woman's clinical care in prison. The prison cooperated fully with this investigation.

The woman was serving a seven year sentence for offences, of which her two daughters were the victims. Her husband and son were sentenced at the same time for associated offences. It was her first time in prison. She was evidently very distressed by her circumstances and began to self-harm frequently by cutting. After she began therapy, in the weeks leading up to her death, the incidents of self-harm reduced significantly

From March 2012, the woman was continuously subject to Prison Service suicide and self-harm prevention procedures and was reviewed regularly. She had regular sessions with a mental health nurse, weekly counselling and was under the care of a psychiatrist. Efforts were also made to keep her occupied in order to help distract her from negative thoughts.

As part of her therapy, the woman wrote down her thoughts and feelings each day which gave some insight into her state of mind. Two days before she died, her eldest daughter had told her that she was breaking off contact with her indefinitely in an attempt to regain custody of her own child. She wrote that she had lost her family and felt lonely and hopeless about the future. Prison staff were unaware of the depth of her feelings. In her final note, she said she could not take any more. She was found hanging in her cell when an officer checked on her at night. Officers and paramedics were unable to revive her.

I am satisfied that the woman was given a good level of support at Downview, although this was not always reflected in fully multi-disciplinary reviews of her risk and some of the monitoring checks were too predictable. She had been monitored as at risk of self-harm throughout her time in prison but was not regarded as a high risk of suicide. As staff were apparently unaware of any indications of a substantial change to her risk, I consider it would have been difficult for them to have predicted or prevented her actions that night. However, I am concerned that the response to the emergency was not as swift as it should have been.

Overall, the woman received some good care at Downview. The prison no longer holds women prisoners and is about to take on a new role as a men's prison, but there are still lessons from this investigation for the new Governor regarding suicide and self-harm prevention and emergency response procedures.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

July 2014

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SUMMARY

1. On 1 March 2012, the woman was sentenced to seven years imprisonment for causing or procuring an act of cruelty to a child under 16 years of age. The victims were her two daughters. At the same time, her husband and son were imprisoned for sexual offences against her youngest daughter. It was her first time in prison.
2. The woman began her sentence at HMP Bronzefield. On 13 March 2012, she self-harmed for the first time by making superficial cuts to her arms. She began to be monitored under Prison Service suicide and self-harm prevention procedures and this continued until her death. On 20 June 2012, she transferred to HMP Downview.
3. The woman harmed herself frequently. In December 2012, she needed a blood transfusion as a result. She was a patient of the mental health team at Downview and a mental health nurse reviewed her regularly. She had weekly counselling sessions and saw the prison psychiatrist. In April 2013, she started dialectic behaviour therapy which appeared to have some success as the frequency of self-harm declined. Her risk of suicide and self-harm was reviewed weekly (with a few exceptions where reviews were held fortnightly as agreed by the case review team).
4. The woman developed good relationships with members of the chaplaincy team at Downview, some wing staff and a small number of prisoners. She took education courses at the prison and attended art, pottery and yoga classes. She had a job as a wing painter during the week and was given a range of hobby and craft materials to help distract her from thoughts of self-harm when she was locked in her cell.
5. The woman found being away from her family very distressing. In January 2013 her eldest daughter had a child. A social services assessment concluded that she should not be allowed contact with her granddaughter. The child was later taken into care. On 24 July 2013, her daughter told her she was breaking off contact with her indefinitely in order to try to regain custody of her child.
6. The woman was encouraged to write down a daily account of her thoughts and feelings and left a significant amount of writing that gives insight into her state of mind. After the conversation with her daughter on 24 July, she wrote that she felt that she had lost her family and had nothing left. She was found hanging in her cell shortly a few days later. Staff and paramedics attempted CPR but sadly she died.
7. We conclude that the woman received a good level of care at Downview, although ACCT reviews could have been more multi-disciplinary and some monitoring checks were at intervals which were too predictable. However, it would have been difficult for prison staff to have predicted or prevented her actions on the night she died. The response to the emergency was not as swift as it should have been.

THE INVESTIGATION PROCESS

8. The investigator issued notices about the investigation to staff and prisoners at HMP Downview inviting anyone with information to contact her. No one responded.
9. The investigator spoke to the Governor by telephone on 29 July 2013. She visited Downview on 5 August and met the deputy governor and the family liaison officer. She visited the wing where the woman had lived and spoke informally to an officer who had known her well. She interviewed two prisoners. She collected copies of her prison record and other relevant paperwork.
10. NHS England (Kent and Medway local area team) commissioned a clinical reviewer to review the clinical care the woman received at Downview. The investigator and clinical reviewer interviewed five members of staff. The investigator spoke to another member of staff by telephone. She gave verbal and written feedback to the Governor and the prison liaison officer about the preliminary findings of the investigation.
11. After the publication of the draft report, the investigator was given a statement by Treasury Solicitors from a prisoner who had been in Downview with the woman. The investigator interviewed her at HMP Holloway. Also at this time the investigator became aware that two officers had returned to work from sick absence. She interviewed one and re-interviewed another by telephone. Security information about another prisoner at Downview was obtained but has not been disclosed.
12. One of our family liaison officers informed the woman's family about the investigation. The investigator and family liaison officer met the woman's mother, step-father and aunt. The woman suffered from fibromyalgia and her family were concerned about whether she had received appropriate treatment for this in prison. They asked why she had been allowed to keep a treasury tag in her cell that she had used to cut herself with. Her family believed that she should have been transferred to hospital under the Mental Health Act. They said that a probation officer had told her that she should divorce her husband and they were unhappy about this. These issues have been addressed in the report.

HMP DOWNVIEW

13. HMP Downview was a closed prison holding about 280 adult women. In September 2013, the Ministry of Justice announced that it would change its role to a category C prison for men. B wing, where the woman lived, held about 40-45 women. B wing was described by staff and prisoners spoken to during the investigation as being for mature and vulnerable prisoners but was not designated as such.

HM Inspectorate of Prisons

14. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Downview in an unannounced inspection in June/July 2013. Inspectors were impressed by the very high quality of activities available to the women. There was a positive atmosphere and relations between staff and prisoners were good. Inspectors found that suicide and self-harm prevention procedures had improved and daily entries in records evidenced caring and supportive interventions. Women spoke highly of the individual care they had received. During the inspection, an inspector spoke to the woman about her experience of Downview and has provided details of this conversation for the investigation.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. The IMB annual report for 2012 commented that the safer custody monthly meetings were effective and well attended. Self-harm remained at the same rate throughout the year. The Board noted that an enhanced case review team had been formed to review the care and progress of vulnerable prisoners with multiple issues. The team met fortnightly and reported to the safer custody committee.

Previous deaths at Downview

16. There have been three previous deaths at HMP Downview, one of which was self-inflicted. We made a number of recommendations in that case about ACCT procedures, the emergency response and family liaison. There are no direct similarities between that case and the investigation into the woman's death.

ACCT (Assessment Care in Custody and Teamwork)

17. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to

reduce this and the extent to which staff need to monitor and supervise the prisoner. Regular multi-disciplinary reviews should be held.

KEY EVENTS

18. On 1 March 2012, the woman was sentenced to seven years imprisonment for causing or procuring an act of cruelty to a child under 16 years of age by allowing her two daughters to have unsupervised contact with her husband's brother, a convicted sex offender, who had sexually assaulted them. Her husband's brother was charged with a number of offences against her daughters but killed himself before his trial. She had pleaded not guilty and always maintained her innocence of the charges. She was taken to HMP Bronzefield the day she was sentenced. Her husband and son were imprisoned at the same time for other offences relating to her youngest daughter. She had not been in prison before.
19. A nurse saw the woman when she arrived at Bronzefield and noted that she suffered from fibromyalgia (a syndrome which causes pain and tenderness in many areas of the body) and osteoarthritis and was receiving amitriptyline (an anti-depressant used in the treatment of fibromyalgia), tramadol (a pain killer) and paracetamol. She said she had no history of mental illness and had not received treatment in the community.
20. On 15 March 2012, a teacher noticed scratches on the woman's arms. She told her she had made the scratches herself two days before, after her mother told her that she had lost her house and the other people in the village where she lived had "turned nasty". This was the first time she had ever self-harmed. An ACCT was opened. During the ACCT assessment interview, she said she felt that she had lost everything. She found it very difficult being away from her family and felt that she had let them down. She told the assessor that making the cuts had relieved painful feelings.
21. The woman was employed in the textile workshop at Bronzefield and completed a self-esteem course in April 2012. She reported feeling depressed by her circumstances and continued to self-harm by cutting. She continued to be monitored under ACCT procedures and had weekly case reviews. On 20 June, she was transferred to HMP Downview.
22. After a short period on the induction unit, the woman lived first on C wing. On 24 August 2012, she moved to B wing (a smaller wing described by staff and prisoners as being for mature and vulnerable prisoners but not designated as such). She began a course in the prison college. In October, when her course commitment reduced to two days a week, she was given the job of wing painter. She also attended yoga, art and pottery classes. She was visited regularly throughout her time in prison by members of her family. She also had frequent telephone contact with family and friends, including inter-prison phone calls with her husband and son. She wrote letters and received emails from her family.
23. The woman told prison staff that she found weekends difficult because she spent more time in her cell with little to distract her from her thoughts. She remained depressed and, on 26 June, a prison GP prescribed her citalopram (an anti-depressant). She was keen on crochet and knitting and was given

materials to do both in her cell to help keep her occupied. When she told staff neither were providing sufficient distraction from intrusive thoughts she was given a variety of different in-cell hobbies and craft materials. Downview had a birds of prey project and she was allowed to visit D wing (the resettlement unit) compound at weekends so she could paint the hawk which was kept there.

24. Prison staff described the woman as quiet and shy at first, but she gradually became more confident and developed good relationships with a small number of prisoners and several staff. She wrote poetry and a daily diary. She often found it easier to raise matters with staff by writing notes to them rather than speaking to them. She had regular contact with members of the Chaplaincy team. She was frequently offered support from the Samaritans and Listeners (prisoners trained by the Samaritans to offer confidential peer support) but always said she preferred not to use them.
25. The woman's ACCT remained open with weekly case reviews (with a few exceptions where reviews were held fortnightly as agreed by the case review team) throughout her time at Downview. She always attended the reviews and took part in discussions about what could be done to support her. She was open about her feelings and the issues she faced. She harmed herself by cutting her arms and legs up to three or four times a week. The cuts appear to have become increasingly deep. She told staff she self-harmed when she was locked in her cell as she had time to think about her situation, her family and the circumstances they found themselves in. She said she found it hard to cope with a range of issues including the progress of her appeal against conviction (she had had two appeals turned down in October 2012 and April 2013), the birth of her granddaughter in January 2013 and the serious illness of one of her nephews in May 2013. She told staff that she felt angry with her husband's brother and found being away from her husband and children very difficult.
26. A mental health nurse-practitioner had assessed the woman on 6 July 2012 and accepted her on his caseload. He regularly attended her ACCT reviews and saw her on a one to one basis, usually on the same day as her reviews. He said she attended all of her appointments and they built up a good rapport. He felt she was honest with him and talked openly about her feelings. He told the investigator that her main concern was her conviction, sentence and the impact on her family. She felt a lot of guilt about what had happened to her daughters and felt she had not been there for her family when they needed her. She felt hopeless and helpless. She spoke to him often about her self-harm. She said she did not intend to end her life but maintained that she would always self-harm in prison. He encouraged her to write down her feelings for discussion when they met.
27. The woman began weekly counselling sessions with the prison counsellor on 18 July 2012. The substance of what they talked about is not recorded in her file, but he made entries in her medical record after each session. Primarily he noted that she did not exhibit any suicidal ideation. Occasionally, he noted

on her ACCT document if she had been in a particularly low mood during their session.

28. On 30 October 2012, the prison psychiatrist saw the woman and recorded that she had told her, "I cut myself because I am angry, I hate myself and I hate other people. I hate myself for not being with my children when they need me'. The psychiatrist noted that she spoke normally and was coherent and spontaneous. She presented as mildly anxious, low in mood and angry but was not psychotic and had no suicidal plans. The psychiatrist diagnosed an adjustment disorder. She prescribed a different anti-depressant (mirtazapine) because the woman told her she did not find citalopram helpful. This was later changed to a third anti-depressant (sertraline) which she appeared to find more helpful. The psychiatrist recommended that she continue to attend counselling with the counsellor and have regular reviews with the mental health nurse.
29. The psychiatrist saw the woman a further five times on 27 November 2012, and 8 January, 26 February, 2 April and 14 May 2013. An appointment scheduled for 18 June was cancelled because the psychiatrist was on long-term sick leave. At the November appointment, they discussed self-harm. The woman said cutting herself lowered her stress and released painful feelings. At the February appointment, she said she was having thoughts of ending her life either by cutting an artery or taking an overdose. The psychiatrist noted this on her ACCT documents and the caremap (a list of actions to reduce risk) was updated to include coping strategies suggested by the psychiatrist. After the April appointment, the psychiatrist recorded that the woman had good days and bad days. On the bad days she self-harmed to get relief and to calm herself down. The psychiatrist wrote that the woman denied having suicidal thoughts.
30. On 11 December 2012, a nurse noticed that the woman appeared unusually pale and short of breath and she was taken to hospital where she had a blood transfusion. When she returned to Downview, she told staff she had been blood letting up to three times after each incident of self-harm. Her blood count was monitored regularly after this. Her observations were increased to four times an hour when she was locked in her cell. She told staff she did not believe that a higher number of observations helped her or prevented her from self-harming
31. On 28 January 2013, the woman applied to social services for contact with her newborn granddaughter. On 19 April, her Offender Supervisor told her that social services had confirmed that she would not be allowed any contact with her granddaughter, either in prison or in the community, until she was 18 years old. At the end of April, her second appeal against conviction was turned down. With the help of her mother, she began the process of trying to find a new solicitor to mount a third appeal.
32. On 23 April, the woman began dialectic behaviour therapy (DBT) which is a psychological therapy developed to help people with a variety of behaviours including frequent self-harm. She attended weekly one to one sessions with

the DBT therapist, and began group work in July. The therapist told the investigator that she had seen her 12 times. They talked in depth about the reasons behind her self-harm. She told her she harmed herself when she was angry with her husband's brother and with herself for being a bad mother. She said she had first begun to feel that way after hearing the trial judge's sentencing remarks. The therapist said she had been very happy with her progress. Her self-harm became less frequent each month and she also devised her own coping mechanisms for helping defer the impulse to cut herself.

33. On 20 June, the woman's mother told her that her granddaughter had been taken into care by social services after an accident at home.

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34. At her ACCT review on 2 July, the woman said she was struggling with feelings of guilt and loss of control about her family. She was unsure what was happening with her granddaughter and she felt angry and resentful about being in prison. She reported that her DBT course was going well but she was feeling quite bleak. She complained of pain from her fibromyalgia and said she had been referred to a pain management clinic. The next day she left a note for night staff which said, "I've cut my arms tonight. They are OK. I'm sorry. I didn't think life could get any worse". The next morning on 4 July, she asked to see a nurse, who dressed her cuts. That afternoon she told an officer that she was worried that her granddaughter would be taken into care permanently. She felt that the offence she had been convicted of and offences committed by members of her family against children, together with other unproven accusations against them, would affect the social services' decision.
35. Also on 4 July, the woman spoke to a member of Her Majesty's Inspectorate of Prisons (who was inspecting Downview that week). She told him that the members of staff who usually attended her ACCT reviews, including mental health staff, knew her well. She said the chaplains were good and she had found the dialectical behaviour therapy helpful. She said that staff at the prison had done "all sorts of things" to help and reassure her. She commented about the lack of things to do at weekends and that she found that the activity packs she had been given as a distraction from self-harm were not challenging enough.
36. On 6 July, a nurse went to see the woman after she did not collect her medication. She told the nurse she did not want to take it. The next day, the nurse noticed bruising to each side of her neck. She had previously presented with a bruise under her armpit which had also spread further down her arm. The woman complained of a sore neck and a doctor examined her the next day. He found no trauma and referred her for blood tests. The results were reviewed the next day by another GP, who noted that the blood results were normal.

37. At her ACCT review on 9 July, the woman said she was concerned that her granddaughter's situation was not being helped by her continued contact with her daughter. The summary read, "She understands intellectually that suicide would not improve things but is struggling to make the connection emotionally".
38. At her next ACCT review on 16 July, the woman was reported to be in a more sombre mood than usual after a difficult dialectical behaviour therapy (DBT) session. There was no further update about her granddaughter. She reported that she was self-harming less frequently and did not feel she was getting the same relief from it. She said she had been writing a lot of poetry and this gave her pleasure. On 17 July, she attended her first DBT group session and was reported to have coped well and been motivated and interested.
39. On 18 July, the woman told staff that her daughter had been advised that in order for her to keep custody of her granddaughter she would have to cease contact with her and other members of her family.
40. The Coroner gave the investigator copies of the woman's daily writing for the period 19-26 July. On 19 July, she wrote that she had been cleaning a cell damaged by fire and was pleased with her work. She had bought some new clothes and was looking forward to a visit from her mother on 21 July, although she said her mother was bringing news about her daughter and she did not know if it would be good news. She had enjoyed pottery class, but was anxious about an appointment in the afternoon with the offender management unit to discuss sentence planning. She wrote that the whole week had seemed to be full of bad things and was not sure whether anything would ever be okay again.
41. The woman did not write on 20 July, but on 21 July she said that her appointment with offender management had been a waste of time. She said they thought she was in denial of her offences and therefore did not fit the criteria of the courses they wanted her to complete. She said it had been lovely to have a visit from her mother, stepfather and aunt. Her granddaughter was still in care. She wrote, "It's all just one horrendous nightmare for everyone. I'm very worried about it and really upset about being so powerless to do anything about it".
42. On 22 July, the woman wrote that she had cut herself for the first time for almost a week and had felt better for it. At her ACCT review on 23 July, she reported that her daughter had a new social worker who seemed more sympathetic to her case. She said she found the issues brought up in her dialectical behaviour therapy sessions hard to process. She said she was successfully keeping herself as busy as possible to distract herself from self-harm. That night, she wrote that she had agreed with the night patrol officer that she would leave the small piece of metal she habitually used to cut herself (the end of a treasury tag) under the door so that neither of them could reach it easily. She said it was an exercise of trust between them.

43. The next day, 24 July, she wrote that she had managed to get through the night without cutting herself. She said lots of things were going through her mind in the wake of her last visit and she was keen to talk to her husband during an inter-prison phone call planned for that afternoon. She said she had finished cleaning the fire-damaged cell and would start painting it the next day.
44. At 5.20pm, an officer wrote on the woman's ACCT document that she was very cheery after the phone call with her husband. She said her husband had been told by his probation officer that he would have to divorce her and she had reassured him that she was not going to leave him. She later wrote that it had been really good to hear her husband's voice and that he was happier because she had reassured him that she was not divorcing him. She also spoke to her daughter for nine minutes on the telephone. At 7.00pm, the officer wrote on her ACCT record that her daughter had told her she had been advised not to be in touch with her mother if she wanted custody of her own daughter. She told the officer that she would probably self-harm that night. The officer offered to get a Listener to keep her company, but she declined.
45. On 25 July, the woman wrote that she felt very down and lonely. She wrote that the previous day her elder daughter had told her that she would be breaking off contact with her for an indefinite period to help her regain custody of her own daughter. She said she now had hardly any contact with any of her children (she was not in contact with her younger daughter). She said she felt numb and almost beyond emotion. She said she felt like cutting, "or something else" and did not know how long she could hold out before doing so. At the bottom of the page she wrote, "This just saves me having a long conversation at the door for everyone else to listen to. Hope you don't mind".
46. At 8.45pm, an officer wrote on the woman's ACCT record that she had passed him a note telling him that she felt very low because her daughter was breaking off contact with her. The officer told the investigator that she was a very private woman and did not like being overheard by other women on the wing, discussing issues about her self-harming behaviour and often used notes to communicate. He said that he wrote a note back to her. He said that he understood her feelings, but that once her daughter regained custody of her granddaughter circumstances would change and she should focus on that time. In the meantime, he advised her to think of herself. Underneath his response, she wrote:

"I don't feel strong enough to do this anymore. I feel now that I have totally failed my children and husband. As things stand right now, I will be without him for another eleven years. I've been with him for twenty-seven years and I feel totally lost without him. I know I have told you before but I still have huge problems trying to think of myself first as I've never done it. It feels wrong and very selfish. DBT is trying to address this issue and I am doing my best. But I've got to the stage where I now truly and honestly think I can't take or cope with any more. I've had enough."

47. The officer told the investigator he remembered the woman passing him a note and writing back to her. He said they had a conversation about what he had written and she indicated she would write another note back to him. However, she did not pass any more notes to him that night. The next time he checked her, she was watching television. According to the ACCT record, she watched television until between 10.45pm and 11.15pm and then went to sleep. On a separate piece of paper, dated 25 July, she wrote that having no contact with her eldest daughter and granddaughter was heartbreaking and she felt stripped of everything.
48. The woman's ACCT entries for 26 July report that she was upset about her daughter but had not self-harmed during the night. An officer said she spent the morning painting on the wing because she could not face going to her pottery class. At 11.00am, he wrote that she had worked very hard all morning but was still very upset. At some point during the day an officer helped her tidy her cell. The officer said she had suffered a sequence of upsetting events. She was facing the prospect of offence-related work and was frightened of looking at it in a classroom scenario, she had received information from her husband and son that they were in the same predicament and she had heard from her daughter that she was breaking off contact with her. However, she never indicated she would end her life.
49. At 3.00pm, the woman went to the wing office for a chat with staff. An officer wrote that she appeared to have taken the news about her daughter "quite well". She said she was painting and keeping busy, but that when she was locked in her cell she started to think and worry about things. During the conversation she received an inter-prison phone call from her son, which was said to have cheered her up.
50. Prisoner A, another prisoner on B wing who was good friends with the woman, told the investigator that she last spoke to her at about 4.30pm. She said that she had told her she could not go on. The prisoner said that the news about her daughter had "ripped her family away from her". The prisoner said she had tried to encourage her to focus on positive things to look forward to, and she knew that staff had done this also, throughout the day. She did not report her conversation with her to staff.
51. The officer on duty as night patrol officer on B wing noticed that the woman had tidied her cell and she told him that another officer had helped her and she was pleased with it. He told the investigator she seemed her normal self but "bubblier". He checked her twice during every hour as required by her ACCT. At 8.45pm, he saw her knitting with blue wool. At the next three checks, at 9.05pm, 9.30pm and 10.10pm, she was watching TV. At the next two checks at 10.45pm and 11.20pm, he said she was writing. On each occasion, he said he spoke to her and asked if she was okay, and she said she was.
52. The officer checked the woman again at about 11.50pm. The light was on in her cell but he could not see her. He knocked on the door and called her name. The privacy curtain was drawn around the toilet. He said his first

reaction was that she was standing by her sink cutting herself, because this was her pattern of behaviour. He listened at the door and thought he heard movement. He checked another prisoner in a cell nearby who was on an ACCT, returned to her cell and knocked again. She did not respond.

53. The officer said he thought the woman was standing at her sink or sitting on the toilet and self-harming. He did not radio for help because he knew she was very private about her self-harm and he did not want the whole wing to know. He ran a short distance to the nearest telephone and rang the Night Orderly Officer (NOO), the officer in charge of running the prison at night, and sought and was given permission to go into her cell. (At night officers do not carry keys but have a cell key in a sealed pouch for use in an emergency which usually requires the permission of the night orderly officer, unless it is immediately apparent there is a life-threatening situation.) The NOO told him to ask the night patrol officer on A wing to assist him. The NOO told the officer that he and the Assist Night Orderly Officer would also come to the wing. The NOO rang his Assist (who was in the security department listening to recorded telephone calls), but got no reply.
54. The officer said he called the night patrol officer and then ran back to the woman's cell. On the way, he collected a medical pack with dressings to treat cuts because he thought she was cutting herself. He broke the seal on his key pouch and, as he put the key in the lock, the night patrol officer joined him. They went into the cell and found her in the corner of the cell by the toilet with a ligature made from wool tied to the piping above her head. (It later became apparent that she had knitted the ligature.) Her feet were touching the floor and her knees were bent. The officer cut the ligature with his cut-down tool which all officers are required to carry. He removed the ligature from around her neck and both men put her in the recovery position.
55. The officer radioed the NOO and asked him to come urgently but did not call an emergency medical code as he should have done. The Assist NOO said he heard this call and realising there might be a problem he left the security department and went to the gate where he met the NOO before going to B wing. Meanwhile, the night patrol officer checked for signs of life but was unable to find any. He and the officer then moved the woman on to her back to try to resuscitate her using cardio pulmonary resuscitation (CPR). The officer began chest compressions and the night patrol officer radioed the NOO and asked him to call an ambulance. The NOO said that he and his Assist were on their way to B wing and began to run while radioing the gate to call an ambulance. The night patrol officer began mouth to mouth resuscitation. When the NOO and his Assist arrived at the cell, the Assist took over resuscitation from the night patrol officer, who went to bring a defibrillator from the B wing office. The NOO telephoned the officer support grade in the gate house to confirm that an emergency ambulance had been called. The ambulance log recorded that the call was made at 00.11am
56. The officers attached the defibrillator. At the same time, the officer collected the emergency bag and gave the Assist a mouthpiece with which to continue mouth to mouth resuscitation. The defibrillator advised not to apply a shock

and the officers continued to take it in turn to administer CPR. The NOO went to C wing and asked the officers there to go to the gate to escort the ambulance crew to B wing. He removed the night double locks from the main gate area and opened all the gates to B wing. Paramedics arrived at 00.24am and took over. The night patrol officer remained in the cell. He found a note on her bed which read, "I'm sorry. I can't take anymore". Paramedics pronounced her dead at 1.02am.

57. In another noted dated 26 July the woman had written:

"Today has been really crap. I didn't go to pottery as I didn't want to be with other people, I just wanted to be on my own. I stayed on the wing and continued painting. I spent a few hours crying this evening. I think it's sinking in. I don't know how to deal with it. I feel totally devastated. I don't know if I've spoken to my daughter for the last time for weeks, months or years. There's so much now I wish I had told or asked her, just normal minor stuff but now it seems so important. I feel totally cut off from my family now. I don't know how to deal with all of this. I feel more lonely now than what I've ever done. I feel like dying right now. I've worked out how to hang myself. I figured that's the least messiest way. I can't do this anymore. I feel I've lost everything that was ever precious to me, my husband and my children and grandchild. All I want is my family, nothing else. I just can't see a way forward. I can't see a future. I feel trapped, and lonely. I'm making everyone else's life a misery by being here and I'm no good to any of them anyway."

Family liaison

58. The woman's next of kin was her husband who was in HMP Isle of Wight. A chaplain at the prison broke the news of his wife's death to him the next morning. At his request, he informed her mother later that day as she was visiting him at the prison. He asked that his wife's mother should be the main point of contact. Downview appointed a family liaison officer who kept in contact with the woman's mother. Her family visited the prison and met staff and prisoners who had known her. In line with national guidance a contribution to the funeral was offered. The prison also held a memorial service, which was attended by members of her family.

Support for staff and prisoners

59. Members of the staff care and welfare team were called to the prison that night. All the staff involved in the attempt to resuscitate the woman stayed on duty and the care team spoke to them. A hot debrief was held at 6.30am and was attended by staff on duty during the incident. A cold debrief was held on 10 September. An officer told the investigator that he had been dissatisfied with the support he had been offered after the woman's death and the investigator fed this back to senior managers. All of the prisoners on open ACCT were reviewed the following day in case they had been adversely affected by her death. Before the other prisoners were unlocked the next morning an officer told the woman's friends, including Prisoner A, that she had died. The prisoner told the investigator that her friends had supported her and

staff had kept an eye on her. She said that healthcare staff had been very supportive. Other prisoners on B wing who had known the woman were also told personally.

Post-mortem examination

60. A post-mortem report gave the cause of death as hanging.

Allegations made by Prisoner B

61. After the publication of the draft report, the investigator was given a copy of an undated statement made by Prisoner B, another prisoner on B wing at Downview. She said the woman had been the victim of verbal abuse by three women who regularly called her a “nonce” and a “dirty old pedo (sic) bastard”.
62. The investigator interviewed Prisoner B at HMP Holloway. She said she had not known the woman very well. She said she witnessed three other prisoners shout abuse at her on B wing and gave examples. She named one of the prisoners but only knew the first names of the other two. She said the woman she named was the ringleader. She said the woman acted like nothing had happened. She said the woman was always talking to staff and knew she had support. She said she did not tell anyone about what she had witnessed until after the woman’s death.
63. An officer told the investigator that the woman was quite a high profile prisoner in Downview because of the nature of her crime and as a result she got called names. He said there was no physical violence. He said the prisoner named as the ringleader by Prisoner B was someone who made comments directed at the woman and other women on B wing. He said this prisoner would never have directly approached the woman and the woman was rarely alone when other prisoners were out of their cell.
64. The officer said the woman was reluctant to ask for help. Sometimes he had noticed her hanging back a bit when she was supposed to go over to healthcare. When he asked her what the matter was she told him she did not want to go over and sit in the waiting room with other prisoners. He said on these occasions he escorted her to healthcare and waited with her. He said she was not the only prisoner in Downview in this position. Sometimes staff in education or healthcare would ask him to come and collect her and others. She used to go over to education with Prisoner A and another prisoner who was in for sexual offences. Her job as wing painter also protected her from any name calling because she was away from other prisoners. He said she was a resilient, dogmatic woman who had an “I don’t care” attitude to bullies. He felt she “stood on the outside” of any name calling.
65. The investigator looked at the woman named as ringleader’s prison security record at Downview. The only reference to the woman was contained in a security information report dated 13 June 2013 which recorded that she had told staff that it was common knowledge on B wing that the woman stole from

cells. The woman was being managed under stage two of Downview's safer prisons strategy (anti-bullying measures).

ISSUES

Management of risk of self-harm

66. The woman clearly found the circumstances of her imprisonment and the separation from her family very difficult to cope with. She began to self-harm prolifically in prison. It is clear from the record and from interviews that the reasons behind her self-harm were her feelings of anger, guilt and grief about what had happened in her family. There were a number of ongoing issues related to her family and her appeal that caused her significant stress. She found it especially hard to be alone with her thoughts.
67. The woman received a good deal of support at Downview from prison officers, health care staff and faith services. She was managed on ACCT and was on the caseload of the mental health team. The prison recognised the importance of keeping her occupied to try to prevent her dwelling on thoughts that might lead to acts of self-harm. She attended the prison college and participated in a number of different classes and activities. She was given a job as the wing painter when her college commitment reduced and was given a number of in-cell hobby and craft materials. She had regular contact with her family through visits, letters, phone calls and email.
68. There appears to have been good communication between officers and mental health staff and between the different members of the mental health team involved in her care. The woman played a full and active part in her management on ACCT and in all of her interactions with different mental health professionals. She appears to have found her participation in dialectical behaviour therapy helpful and this contributed to a reduction in the extent of her self-harm in the months before her death. She also received counselling and had the support of a named nurse from the mental health team. She told a member of Her Majesty's Inspectorate of Prisons that staff had done "all sorts" to support and reassure her. We consider that the prison made good efforts to provide appropriate support for her.
69. We have reviewed all of the woman's considerable ACCT documentation and are satisfied that the ACCT procedures were generally of a reasonable standard. Reviews were held once a week throughout her time at Downview and caremaps to address her risk factors were appropriate and frequently reviewed. She was usually observed at least once an hour during patrol state (when prisoners are locked in their cells). At times, her observations were increased to three or four times an hour in response to stressful life events. She had two case managers at Downview. Both consistently chaired her reviews and provided continuity of care. Her mental health nurse attended approximately a half of the case reviews. Her counsellor, the psychiatrist and the DBT therapist all wrote in her ACCT document at various times to record if she had been in a low mood. The entries from officers show some enjoyed a good relationship with her.
70. While it is commendable that a range of staff were involved in the woman's care at Downview, their input was not always reflected at case reviews and

most involved just the case manager, an officer from the wing and her. Prison Service Instruction 64/2011, which gives guidance on how to manage suicide and self-harm procedures, states that case reviews should be as multi-disciplinary as possible and should involve representatives from as many relevant departments as possible. In this case, we would have expected consistent input from the mental health team and frequent input from others involved in her care and with whom she had contact, such as members of the chaplaincy. We make the following recommendation:

The Governor should ensure that ACCT reviews are multi-disciplinary and involve all staff who can contribute to the care of a prisoner at risk.

71. We have considered whether staff at Downview should have discussed the possibility of increasing the level of observations required after the woman spoke to her daughter on 24 July. We are sure that the members of staff on duty were aware of the potential significance of the conversation, as her self-harm was directly linked to her feelings about her family situation, but this had been ongoing for some time and there was little to indicate to staff that this was a particularly significant incident which seriously increased her level of risk. She had generally been regarded as a risk of self-harm rather than suicide. Her self-harm had been limited to cutting and had reduced in frequency after she began to attend dialectical behaviour therapy.
72. Had the officer received the woman's written response to his note of 25 July, in which she said she could not cope anymore and had had enough, then it is possible that this would have prompted an ACCT review to discuss this with her and re-assess her level of risk. Without this, there was little to suggest that her level of risk had increased significantly. In retrospect, the fact that she tidied and rearranged her cell on the day she died looks ominous as this is a pattern sometimes seen in suicidal people, but we do not consider that prison staff should have been able to identify this at the time, unless it was exceptionally out of character. Overall, we consider that it was not unreasonable in the circumstances for the level of observations to have remained the same. It is clear that the officer knew her well and made checks on her throughout the night. While she was always an acknowledged risk of self-harm, we consider it would have been very difficult for prison staff to have predicted and prevented her actions on 26 July.
73. However, we note that many of the monitoring checks were at intervals which were too regular. This had been also been identified by the Deputy Governor at her management check at 8.45am on 26 July. That evening the officer's checks were at more irregular intervals, but on several previous occasions checks had been made every half hour. Although it did not have an impact in this case, it is important that checks are conducted at random intervals within the specified frequency otherwise prisoners can predict a window of opportunity if they are planning to take their own life. We make the following recommendation:

The Governor should ensure that ACCT observations are conducted at random intervals within the specified frequency.

The emergency response

74. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes provides guidance to staff on communicating the nature of a medical emergency and ensuring there are no delays in calling ambulances. Paragraph 5.4 says:

“A representative NHS Ambulance guide for use in the community states that an ambulance should be called when there are signs of chest pain, difficulty in breathing, unconsciousness, severe loss of blood, severe burns or scalds, choking, fitting or concussion, severe allergic reactions or a suspected stroke. This must also be the case for prisoners and therefore, in these situations when the emergency is called over the radio network an ambulance must be called immediately.”

Annex A to the PSI sets out the mandatory contingency responses to emergency codes and requires that when a code blue or code red (or alternatively code one or two) is called ‘Communication control room automatically calls an ambulance and awaits update from the scene’. Downview has a local staff instruction which states that the communications room should call an ambulance whenever an emergency code is used.

75. There was no dedicated communication control room at night in Downview at the time of the woman’s death, but the officer support grade in the gate house had access to a radio. When the officer called for permission to enter the cell, the NOO was in the gate house. While he was on his way to the cell, the officer and the night patrol officer radioed and asked for him to come urgently and an ambulance to be called. The NOO tried to radio the officer support grade to ask her to call an ambulance. The officer did not use a code to describe the nature of the emergency as he should have done. When the NOO got to B wing he said he was unsure if the officer support grade had heard his call because he had been running and could not hear her response. He therefore telephoned her to make sure an ambulance had been called. In her incident log, the officer support grade recorded that she received his request for an ambulance by telephone at 0.10am. She dialled 999 at 00.11am.
76. The lack of a contemporaneous communications log means that it is difficult to be certain of timings. Both officers both said that they entered the woman’s cell before midnight. They cut her down and began cardiopulmonary resuscitation before radioing the NOO and requesting an ambulance. A second statement from the night patrol officer reports that he was told after her death that he and the officer used their radios to call the emergency at 00.02am and 00.04am respectively. We have not seen documentary evidence of this, but there appears to have been a significant delay before the ambulance was called, which evidence suggests was at 00.11am. Two paramedic cars and an ambulance arrived at the gate at 00.24am. A second ambulance arrived at 00.30am.

77. It is unclear whether the delay in calling an ambulance would have made any difference to the outcome for the woman. Staff quickly attempted to resuscitate her and had access to emergency equipment. However, it does not appear that an emergency code was used and that an ambulance was called immediately as a result.
78. We are satisfied that there was an appropriate local policy to instruct staff in the communication room during the day to call an ambulance whenever an emergency code is used and that staff have been reminded that this is what should happen. However, as there are no staff in the communications room overnight, we do not consider that the policy gives adequate guidance for staff on nights or that it was clear who had responsibility for calling an ambulance. We believe that the instruction needs to be clarified to ensure that ambulances are called at night. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Downview has an appropriate Medical Emergency Response Code protocol which clarifies procedures at night, provides guidance to staff on efficiently communicating the nature of a medical emergency, and ensures there are no delays in calling an ambulance.

Allegations made by Prisoner B

79. Prisoner B said she had witnessed the woman and other prisoners being verbally abused by three prisoners on B wing. She was able to identify one of them, the alleged ringleader. An officer confirmed this prisoner had made comments about the woman's offence. The investigator examined this prisoner's security file. The only reference to the woman was in relation to her giving information to staff. The woman was being managed on stage two of Downview's safer prisons strategy. We are satisfied that the prison had identified the woman as a bully, were aware of her activities and behaviour and appropriate measures were being taken to manage her. We are also satisfied from the significant amount she wrote and what she said to Prisoner A and members of staff, that the verbal abuse directed at the woman was not a significant factor in her death.

Questions asked by the woman's family

80. The woman's family asked about the management of her fibromyalgia at Downview. When she arrived at Downview, she was receiving tramadol and amitriptyline for her fibromyalgia. She was also receiving paracetamol (a pain killer) and diclofenac (an anti-inflammatory). Her GP records show that she had been on 200mg of tramadol daily in the community, but arrived at Downview on 400mg daily. She was also receiving a higher dose of amitriptyline than was usual to treat fibromyalgia. She saw a doctor, who decided to try to wean her off tramadol because of concerns over its safety and because it is often traded in prisons. She remained on the same dose of amitriptyline, but she was last prescribed tramadol on 17 July and then it was abruptly stopped. The tramadol was replaced by a variety of different analgesics. In January 2013, she was prescribed nefopam (another painkiller) and from February 2013 the diclofenac was replaced with naproxen (an anti-inflammatory). On 28 June, she was referred to a pain management clinic but does not appear to have attended before her death.
81. The clinical reviewer is critical of the fact that the woman's tramadol was stopped abruptly and not titrated down. He makes a recommendation in his review that, in future, a plan is made to reduce the level of tramadol in such circumstances. As this does not appear to have been a factor in her death, we do not repeat the recommendation here. Various different combinations of anti-depressants, anti-inflammatories and pain killers were tried in response to symptoms reported by her. Overall, he is satisfied that her medical care at the prison was equivalent to that she would have received in the community.
82. The woman's family questioned why she had been allowed to keep a piece of metal that she used to self-harm. There are numerous entries in the ACCT document where staff asked her to hand over a treasury tag, which they believed was the item that she used to scratch and cut herself, but she refused. While it would have been possible for staff to forcibly search her and her cell we consider this would have had little positive benefit and would have been likely to cause her further distress. She had many other items in her cell which she could have used to harm herself with, including knitting and crocheting needles. The most effective way to remove all items a prisoner might use to harm themselves with would be hold them in inhumane bare and strip conditions and even then some prisoners find the means. We believe that it was reasonable in the circumstances not to pursue this issue when there was a corresponding risk of distressing her still further.
83. The family said they strongly believed that she should have been transferred to hospital under the Mental Health Act instead of remaining in prison. One of the prison GPs said that he did not consider that the woman exhibited behaviour that would have warranted sectioning and detention under the Mental Health Act. Although her self-harm was prolific, it was also stable for a long time. She did not directly express any suicidal ideation to him and did not appear to be a risk to others. She was also compliant with her medication. The investigator was unable to interview formally the prison psychiatrist because she was abroad for family reasons, but she spoke to her

by telephone. She said that the woman was not psychotic and she had not considered her suitable for transfer to a secure mental health facility. She believed that she was being well supported by the mental health services at Downview and that dialectical behaviour therapy was an appropriate intervention to help treat her self-harming behaviour. The clinical reviewer said from the evidence available from records and interviews he agreed with this view. We are satisfied that there were no grounds to suggest that she ought to have been transferred to hospital.

84. The family said they were upset that a probation officer had told her that she would have to divorce her husband. There is no evidence that any member of probation staff said this to the woman. She reported that her husband had told her in their last phone call that his probation officer had suggested this but is not within the power of the probation service to tell prisoners whether or not they should divorce. It seems that she was able to reassure her husband that she would not leave him and reported that she was pleased she had been able to cheer him up and we are satisfied that this appears to have been a misunderstanding.

RECOMMENDATIONS

1. The Governor should ensure that ACCT reviews are multi-disciplinary and involve all staff who can contribute to the care of a prisoner at risk.
2. The Governor should ensure that ACCT observations are conducted at random intervals within the specified frequency.
3. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Downview has an appropriate Medical Emergency Response Code protocol which clarifies procedures at night, provides guidance to staff on efficiently communicating the nature of a medical emergency, and ensures there are no delays in calling an ambulance.

Action Plan

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that ACCT reviews are multi-disciplinary and involve all staff who can contribute to the care of a prisoner at risk	Accepted	<p>All Supervising Officers and Custodial Managers will receive refresher training in ACCT Case Management.</p> <p>Training will be provided to staff completing management checks to ensure that they check case reviews are multi-disciplinary.</p> <p>All reviews will be highlighted at the daily morning meeting and relevant departments will be asked to confirm their attendance.</p>	<p>August 2014</p> <p>Head of Residence & Safer Custody</p>	
2	The Governor should ensure that ACCT observations are conducted at random intervals within the specified frequency.	Accepted	<p>Staff will be briefed via a Notice to Staff, Staff Bulletin and ongoing Introduction to Safer Custody training of the requirement to conduct observations at random intervals.</p> <p>Training will be provided to staff completing management checks to ensure that they check appropriate observations are completed.</p>	<p>October 2014</p> <p>Head of Residence & Safer Custody</p>	