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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death in December 2013 of a  
prisoner at HMP Low Newton**

## ***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 died in December 2013, after she had been found hanging in her cell at HMP Low Newton. I offer my condolences to her family.

One of my lead investigator and a clinical reviewer reviewed the clinical care that the woman received at the prison. The prison cooperated fully with the investigation.

The woman had a history of psychiatric problems and had made a number of previous suicide attempts. She had been hospitalised twice in 2013. When she was discharged from hospital on 7 November, she threatened to kill a former partner and was arrested and remanded into custody. She had never been in prison before.

As soon as she arrived at Low Newton, the woman was identified and monitored as a high risk of suicide. Over the next three weeks, prison staff held 21 case reviews to help manage her care. The woman tried to hang herself several times and she spent most of time in the prison's healthcare unit, sometimes for extended periods in specially designed safer cells. There was a gap in support from the mental health team when a nurse went on leave and she was not referred to a psychiatrist until 22 November. The psychiatrist who saw her on 27 November concluded that prison was not an appropriate place for her and recommended that she should transfer to hospital. Arrangements for a move began. On 30 November, a case review decided that the woman should move from a safer cell to a standard cell. The next day, she was found hanging in her cell and was taken to hospital, where she died.

It is not within my remit to consider whether prison was ever an appropriate place to care for someone as unwell as the woman, but this must be in doubt. I am, therefore, concerned that she was not referred to a psychiatrist until nearly two weeks after she arrived at the prison, which delayed any possible transfer back to hospital.

I agree with the clinical reviewer that, in many respects, healthcare staff made impressive efforts to support the woman. Staff immediately recognised her distress and held frequent multidisciplinary case reviews, although given the complexity of the case, an enhanced case management process ought to have been considered. However, it is of concern that healthcare staff believed that prison managers did not always give sufficient weight to their clinical opinions about the woman's risk to herself and that she was moved from a safer cell shortly before her death without the input of mental health staff overseeing her care. The investigation also identifies some deficiencies in emergency procedures and in the timely notification of the woman's parents of their daughter's admission to hospital.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

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## SUMMARY

1. The woman had a history of mental health problems and, after a long period of stability, her mental health deteriorated seriously in 2013. She made numerous attempts to kill herself and was admitted to psychiatric hospital in August and October. On 7 November, she was discharged from hospital to the care of a community crisis team and immediately threatened to kill a former partner. When the police arrived, she held a knife to her own throat. A doctor at the police station decided that the woman would not benefit from a further hospital admission. She was charged with making threats to kill and possession of a knife in a public place.
2. On 9 November, the woman appeared at court and was remanded into the custody of HMP & YOI Low Newton. This was her first time in prison. A reception nurse was concerned about her and began suicide and self-harm monitoring (known as ACCT procedures). She advised that the woman should be constantly supervised, but prison staff set observations at four times an hour. The woman was allocated a standard cell in the healthcare unit, but tried to hang herself twice that evening. She was then moved to a safer cell and constantly supervised. On Sunday 10 November, a mental health manager carried out an emergency mental health assessment. She concluded that the woman should continue to be constantly supervised in a safer cell and requested further information about her recent psychiatric care.
3. Staff conducted daily ACCT case reviews and, on 12 November, the case review panel reduced the frequency of observations to four times an hour. On 13 November, the woman moved from the safer cell to a standard healthcare cell and, on 14 November, she moved from the healthcare unit to the prison's induction unit.
4. Nine case reviews were held between 14 and 26 November while the woman lived on the induction unit. She had been allocated a mental health keyworker, but this nurse went on leave without any cover being arranged. The woman herself raised this issue and a new keyworker was allocated.
5. The woman's tried to hang herself on 16 November and was moved to a safer cell for 24 hours. She tried to hang herself twice on 22 November and was moved back to a safer cell and referred to a psychiatrist. On 26 November, staff relocated the woman to a safer cell in the healthcare unit and carried out daily case reviews. On 27 November, a consultant forensic psychiatrist assessed the woman and recommended her transfer to hospital. On 28 November, the woman repeatedly banged her head against the cell door. On 29 November, she refused to attend her case review.
6. On Saturday 30 November, the ACCT case review panel moved the woman to a standard healthcare cell. No one from the mental health team was involved in this decision, partly because they do not work at the weekend. A healthcare support worker became concerned that evening when the woman asked her how frequently she was being watched and whether the healthcare staff on night duty had a key to her cell. The woman also gave the support worker her next of kin details which she had previously withheld. The support worker noted all of this in the ACCT ongoing record and reported her concerns to the nurse in charge. The nurse in charge did not formally raise

the level of supervision, but asked another nurse who was taking over the unit for night duty to check the woman more frequently than the expected four times an hour. The nurse in charge did not record the reasons for her decision in the ACCT document.

7. On Sunday 1 December, a case review panel decided that the woman should remain in a standard cell and continue to be checked at least four times an hour. The case review did not discuss the healthcare support worker's concerns from the evening before or whether this had any impact on the level of risk.
8. At 6.50pm on 1 December, the healthcare support worker was concerned that she could not see the woman when she went to check her and could not obtain a response. She was alone in the healthcare unit at the time and therefore radioed for help. Staff attended and unlocked the door. They found the woman behind a privacy curtain used to screen the toilet area of the cell, hanging by a sheet attached to the window. The staff cut the sheet and began to try to resuscitate the woman. No one called a medical emergency code to alert other healthcare staff to the emergency and an ambulance was not requested until six minutes later. Control room staff had little information about the incident and could not convince the emergency services operator that the call was a high priority until a supervising officer at the scene spoke directly to the operator. A first ambulance arrived at 7.05pm. The woman was taken to hospital but, sadly, died the next morning.
9. The woman's behaviour and mood were extremely unpredictable and it is questionable how much prison staff could be expected to do to manage someone with her evident level of mental distress without the resources of a fully staffed psychiatric unit. All of her attempts at hanging herself were serious and demonstrated clear suicidal intent. It is evident that the woman's mood swings made her a very difficult person to manage and there were frequent ACCT reviews which were mostly of a good standard. Most reviews were multidisciplinary and the woman lived in safer cells for extended periods. However, there were too many different ACCT case managers and we consider that the enhanced case management process, available under Prison Service suicide and self-harm prevention procedures, should have been used to manage the level of risk she presented. The ACCT care map was not updated for a week before the woman died and information which might have influenced a decision about the level of the woman's risk on the night before she hanged herself was not fully documented and not considered by the case manager at the next ACCT case review on 1 December.
10. We agree with the clinical reviewer that, as the woman was already known to community psychiatric services and was a serious risk to herself from the moment she entered prison, she should have been referred to a visiting psychiatrist at the earliest opportunity. No arrangements were made to cover the work of the woman's mental health keyworker to ensure continuity of care when her keyworker went on leave.
11. There were several occasions when prison managers chose not to follow the advice of clinical staff and we were concerned to hear that some healthcare staff believed that their contributions were not given sufficient weight by prison staff. The decision to move the woman out of the safer cell on 30 November

was taken without input from the mental health team, even though the woman's behaviour was extremely unpredictable at the time, she was under the care of the mental health team and was due to transfer to a psychiatric hospital. We consider that someone from the mental health team should have been involved in all decisions about her care. We accept that their absence at weekends can make this difficult, but it would have been prudent to have waited until their opinion had been obtained. An enhanced case management process would have helped avoid this.

12. The emergency response was poorly coordinated and communication broke down. Staff did not follow the prison's local policy or national instructions. The correct emergency medical response code was not used and control room staff were not given basic information about the incident. The prison and the local ambulance service need to agree a protocol to ensure that requests for emergency ambulances are dealt with more effectively in future.
13. Finally, prison managers decided not to tell the woman's family about her critical condition because of a comment her mother had made in a telephone call three weeks earlier. We consider that this decision was wrong and contrary to the mandatory requirements of Prison Rules. We make eleven recommendations as a result of the investigation.

## **THE INVESTIGATION PROCESS**

14. Notices were issued to staff and prisoners at HMP & YOI Low Newton about the investigation. No one responded. The lead investigator and another investigator visited Low Newton on 12 December. They collected copies of the woman's clinical and prison records and went to the reception, healthcare and induction units. They interviewed 22 members of staff in January 2014. They gave verbal and written feedback to the Governor about the initial findings of the investigation. The lead investigator subsequently interviewed five other members of staff by telephone.
15. NHS England appointed a clinical reviewer to review the woman's clinical care at the prison. He attended the interviews with the PPO investigators.
16. We have sent the local Coroner a copy of this report.

### **The woman's family**

17. One of the PPO's family liaison officers contacted the woman's mother to explain the investigation process. The woman's mother provided very helpful background information about her daughter and wanted to know where her daughter was located in the prison and how often she was checked by staff. The woman's mother was provided with a copy of the draft report.



## **HMP LOW NEWTON**

18. Low Newton is a women's prison on the outskirts of Durham. Primary healthcare is provided by Care UK. Mental health care is provided by Tees, Esk and Wear Valleys NHS Foundation Trust, and is available from Monday to Friday. At the weekend, a mental health manager is available on-call for advice and can attend the prison if a prisoner is in crisis. The healthcare unit is staffed 24 hours a day. Two forensic consultant psychiatrists each hold a half day clinic every week. There is a dedicated unit for sentenced women prisoners with severe personality disorders who are assessed as dangerous.

### **Her Majesty's Inspectorate of Prisons**

19. HM Inspectorate of Prisons last inspected Low Newton in 2011. Inspectors found the prison to be reasonably safe. Incidents of self-harm had reduced since the previous inspection. However, inspectors noted that there were too many male members of staff for a women's prison, including too many male senior managers. Too few officers had received specific training in working with women prisoners. Inspectors asked the prison to increase the percentage of female officers to 70 percent. Inspectors found that good support was provided for new arrivals at risk of suicide and self-harm and that ACCT procedures were generally good. They noted that women who required a transfer to a secure mental health bed were usually transferred relatively quickly, although not all were moved within 14 days of assessment.

### **Independent Monitoring Board**

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In the IMB's most recently published annual report for 2011-2012, the board questioned whether Low Newton was suitable for women with serious mental health problems and asked whether women could be diverted to hospital from court. The IMB reported that staff demonstrated genuine concern for the welfare of women and that the healthcare staff coped admirably for prolonged periods with seriously mentally ill and volatile women. The board noted that staff frequently had to prevent women from attempting to hang themselves.

### **Previous deaths**

21. Since the Ombudsman began investigating deaths in prisons in 2004, we have investigated two deaths at Low Newton. One woman hanged herself and another died of an overdose of prescription and non-prescription drugs. Neither investigation highlighted any issues directly related to the circumstances of this investigation.

### **Assessment, Care in Custody and Teamwork (ACCT)**

22. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the 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. Checks should not be at

predictable intervals to prevent the prisoner anticipating when they will occur. If a prisoner is considered to be at very high risk of suicide, staff can implement constant supervision, which means the prisoner must be watched at all times. Part of the ACCT process involves assessing immediate needs and drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the care map have been completed.

### **Safer cells**

23. Safer cells are specially designed to make it difficult for a prisoner to hang themselves. The safer cells at Low Newton are painted white and the furniture is moulded into the fabric of the cell. The bars on the window are covered with perspex. The prisoner can be observed from a viewing panel in the door, and is allowed bedding and reading material. However, a woman in a safer cell is not allowed a television or any other item which she might use to harm herself. Safer cells were used on 67 occasions at Low Newton in 2013 for a total of 136 days. The safer cells at Low Newton comply with the latest Prison Service guidance.

## **KEY EVENTS**

24. The woman had been discharged from mental health services in 2004. After a long period of stability, she began to have suicidal thoughts in 2013. In the summer of 2013, she was admitted to Greentrees Psychiatric Intensive Care Unit (PICU), Gosforth, under the Mental Health Act. While she was there, she attempted to hang herself.
25. The woman was discharged from Greentrees, but was subsequently detained by the police on 28 October after being found on a bridge threatening to drown herself. She was admitted to St George's Hospital in Morpeth, where she cut herself, tried to hang herself three times and threatened to stab herself in the neck. She also tried to escape and had to be restrained on one occasion for the safety of other patients.
26. On 7 November, the woman was discharged into the care of a community crisis team with a diagnosis of emotionally unstable borderline personality disorder. Her discharge summary indicated that there were 'no behaviours indicative of risk' and that the woman's admission as an inpatient had only increased her risk of suicide and self-harm. Her major risk factor was noted as being the end of a relationship. The woman was due to attend an appointment with her care coordinator on 11 November.
27. Police arrested the woman within hours of her discharge from St George's. She had gone to a former partner's address with a knife and had fled when the police were called. When the police found her, she had held the knife to her own throat. A hostage negotiator resolved the situation and the woman was detained temporarily under the Mental Health Act. A doctor assessed her at the police station and concluded that the woman would not benefit from a further inpatient admission and that she could be dealt with by the criminal justice system. Her temporary detention under the Mental Health Act was therefore rescinded, but the woman remained in police custody.
28. On 8 November, the woman tried to pull a blanket tightly around her neck in the police station and was then constantly supervised. The police completed a suicide and self-harm warning form to accompany the woman to court and prison to alert them of the risk. On 9 November, the woman appeared at South East Northumberland Magistrates' Court charged with making threats to kill and possession of a knife in a public place. An escort officer constantly watched her in the court cells. She was remanded into custody and taken to Low Newton.

## **HMP & YOI Low Newton**

29. Nurse A assessed the woman when she arrived at Low Newton on the afternoon of Saturday 9 November. The nurse was aware that the woman had been subject to constant supervision at court. The woman was tearful and said that she had no support in the community. The nurse was very concerned about her and opened an Assessment, Care in Custody and Teamwork (ACCT) suicide and self-harm monitoring document. She recommended constant supervision, the first time she had done so for a prisoner in reception. She referred the woman to the mental health team.

30. Supervising Officer (SO) A and SO B spoke to the woman to complete an ACCT immediate action plan. SO A described the woman as rather odd and peculiar, but very lucid. She told the investigator that the woman seemed quite together and that they had had a perfectly reasonable conversation. The woman told her that she had just been discharged from psychiatric hospital. She spoke about two of her partners and her pets and gave a lot of information about her circumstances. The two SOs consulted the duty governor and custodial manager, A, and decided that constant supervision was not needed at that time. They set the frequency of checks at four an hour and the woman moved to a standard cell in the healthcare unit.
31. For the next few hours, the woman was described as extremely agitated. She paced the floor and threatened to hang herself. Nurse A became worried about her and asked a prison officer to open the cell. They found the woman hanging by a sheet attached to her window. The staff removed the sheet from around her neck and the woman recovered quickly.
32. SO A obtained duty governor A's permission to move the woman to a safer cell in the healthcare unit and to begin constant supervision. The woman immediately tied her socks around her neck, but an officer intervened and she quickly recovered again. The SO held an emergency ACCT review at 7.40pm. The woman was very tearful and distressed and the review team, which included Nurse A, decided to keep the woman in the safer cell under constant supervision. The panel assessed the woman as a high risk of harm to herself at this review and every other subsequent ACCT review held while the woman was at Low Newton.
33. In the early hours of the following morning, Sunday 10 November, Nurse B telephoned Dr A (the out of hours doctor) to obtain permission to give the woman medication. The doctor authorised Nurse B to issue the woman mirtazapine (an antidepressant) and paracetamol at 1.15am.
34. The woman had an ACCT assessment interview on the morning of 10 November, after which SO A chaired the first formal ACCT case review. The review decided that constant supervision should continue in the safer cell in the healthcare unit. The SO added three issues to the woman's ACCT care map: medication, mental health issues and contact with her partner to resolve the status of their relationship. Staff actions were to contact the woman's community GP to confirm her medication, to contact the duty mental health manager for an emergency assessment and to encourage the woman to write a letter to her partner. Nurse C, who was in charge of the healthcare unit that day, had attended the case review and afterwards telephoned the on-call Mental Health Manager, A, to ask for an emergency mental health assessment.
35. The Mental Health Manager A assessed the woman that afternoon. She agreed that the woman should continue to be constantly supervised in the safer cell and arranged for documents relating to her recent psychiatric care to be faxed to the mental health team. The Mental Health Manager left a message for the woman's care coordinator, asking her to contact the prison's mental health team.

36. On Monday 11 November, the woman's case was allocated to Nurse D from the mental health team and she went to see her. At the second ACCT review later that day, led by the head of safer custody and attended by Nurse D, it was agreed that the woman would receive daily input from the mental health team. The woman remained in the safer cell in the healthcare unit under constant supervision. SO C telephoned the woman's mother that day to ask if she was happy for her telephone number to be added to her daughter's list of authorised numbers. Her mother said she did not want her number to be added at that time.
37. On 12 November, the woman appeared at South East Northumberland Magistrates' Court via videolink. The magistrates did not grant bail and the case was committed to Newcastle Crown Court. The woman took the news very badly. She refused to return to her cell and became aggressive towards the staff. Staff used control and restraint techniques and handcuffs to escort her back to the healthcare unit. She was placed on a disciplinary charge because of her behaviour.
38. The woman refused to attend her third ACCT case review that afternoon. The person who chaired the review, spoke to her in her cell. He said that she did not seem distressed, but still declined to attend. He briefed the ACCT review panel about his conversation with the woman. The review decided that she should stay in the healthcare unit safer cell, but her observations should be reduced to four times an hour. Nurse D attended the review and was concerned about the decision to end constant supervision as she believed that the woman would continue to try to take her own life. The nurse described the discussion as 'intense'. The man who chaired the review told the investigator that the panel had a long discussion, but were in agreement at the end of the review. He wanted to integrate the woman into prison life, initially by ending constant supervision before moving her out of the safer cell the next day and then out of the healthcare unit the day after.
39. The same day, the healthcare manager discussed the woman with the man's care co-ordinator, her care coordinator in the community. Dr B, a prison GP, assessed the woman later in the afternoon after staff had ended constant supervision. The doctor kept her on the same medication she had been prescribed earlier.
40. The next day, 13 November, the woman attended an adjudication hearing after her disruptive behaviour in the videolink suite. She was found guilty of disobeying a lawful order. Duty Governor A was conducting the adjudication, gave her a suspended punishment of seven days loss of association and canteen for three months, because of ongoing concerns about her safety. The officer who chaired the fourth ACCT review the same day. The panel decided to move the woman from a safer cell to a normal cell on the healthcare unit. She was still checked four times per hour.
41. A fifth ACCT case review, on 14 November, decided that the woman should move to a standard cell on E wing, the prison's induction unit. The frequency of observations remained at four an hour. Two issues were added to the woman's ACCT care map: benefits and money worries and the loss of her flat. The action to address these issues was to arrange an appointment with a

member of staff from the prison's offender management unit. The woman moved to E wing that afternoon.

### **The woman's stay on E Wing from 14 to 26 November**

42. On Saturday 16 November, two days after moving to E wing, the woman's mood deteriorated. She was very tearful and said that she had nothing to live for. Wing officers asked Nurse E from the primary care team to see her because the mental health team do not work at the weekend. The nurse offered to move her to a safer cell or to the healthcare unit, but the woman declined. The nurse discussed her concerns with wing officers. As the woman had not mentioned any specific plans to kill herself, they decided that there was no need to change the management of her risk. The woman remained in a standard cell on E wing and the staff continued to check her four times each hour.
43. Later that evening, an officer found the woman with a plastic bag tied around her neck. Staff removed it and the woman recovered. The staff held a sixth ACCT review in response to the incident and the woman was moved to a safer cell on E wing. The level of checks remained the same.
44. At the seventh ACCT review the next day, 17 November, the woman said that she did not currently have any suicidal thoughts. The review agreed that she should move back to her standard cell on E wing and be checked four times each hour. The location and frequency of observations were maintained at the eighth ACCT case review the next day. SO D added another issue to the ACCT care map, effectively restating that the woman was worried about her accommodation but also that she was concerned about what would happen to her pets, which a neighbour was temporarily caring for. The action was for a member of staff from the housing department to speak to the woman.
45. On 20 November, a member of staff from the prison's offender management unit saw the woman to discuss her accommodation and money worries. Her mood became more erratic later that day. She refused to get out of bed and said that she had not eaten for two days. She saw Nurse A during her induction and asked about the daily input she was supposed to be getting from the mental health team. During the evening, the woman asked to see Nurse A, but she was unavailable. Another nurse attended and promised that Nurse A would see her the next day.
46. The same evening, the woman asked for a screw in the wall of her cell to be covered because it was 'taunting her'. She relaxed once it was covered. Nurse F (who worked on the detoxification unit adjacent to E wing) checked her and the woman told her that she had not seen her mental health keyworker since she had moved to E wing almost a week earlier. The nurse advised the mental health team of this.
47. On 21 November, Nurse A went to see the woman, who again said that her mental health keyworker had not been to see her. The nurse spoke to a member of the mental health team and found out that Nurse D, the woman's allocated mental health keyworker, had gone on leave and no cover had been arranged. Nurse G and Nurse H from the mental health team reviewed the woman on E wing that evening. The woman was tearful and reported having

suicidal thoughts. Nurse G suggested to prison managers that the woman should be moved to a safer cell, but she remained in her normal cell on E wing.

48. On 22 November, the woman tied a sheet around her neck in an attempt to strangle herself. She was slumped behind her cell door, which made it difficult for staff to get into the cell. She was moved to a safer cell on E wing where she immediately tried to tie her socks around her neck. At 2.50pm, SO E chaired the ninth ACCT case review and decided that the woman should stay in the safer cell on E wing with four checks an hour (the same frequency as before). Nurse F attended the ACCT case review but remained so concerned about the woman that she decided to perform extra checks of her own.
49. At 3.40pm, Nurse I and Nurse G, from the mental health team, visited the woman. The woman was very tearful and said that she wanted to die and was angry that officers had found her in time to save her life. Nurse I made a referral for the woman to see a psychiatrist and she asked prison staff to begin constant supervision. The SO spoke to the duty governor and they decided that this was unnecessary because the woman had not attempted to kill herself again in the hour since the ACCT review.
50. On 23 November, SO G chaired the tenth ACCT case review. The woman remained in the E wing safer cell with observations four times an hour. The next day, 24 November, the SO chaired the eleventh ACCT case review and maintained the same location and frequency of observations. Later that day, the woman tied strips torn from a towel around her neck. SO F held an ACCT case review immediately. Any items which the woman might have used to harm herself were removed from her cell. She continued to be checked four times each hour.
51. On 25 November, Nurse I was allocated as the woman's mental health keyworker. At the thirteenth ACCT review, the woman was tearful, low and apologetic. She remained in the E wing safer cell with four checks an hour. SO A, who had attended the ACCT review, updated the woman's ACCT care map. She noted that members of staff from both the offender management unit and the housing department had now spoken to the woman about her accommodation and money worries (although these had not yet been fully resolved). After the review, Nurse J asked Dr B to review the woman's medication. The doctor checked the woman's notes and re-prescribed trazadone and mirtazapine.
52. That evening, the woman began to express paranoid ideas to prisoners and staff about Officer A, who worked on E wing. She talked about cutting his throat and was very agitated and emotional. Nurse F was extremely concerned about the deterioration in the woman's mental state. She did not want the woman to remain in her current location and thought that she would try to hang herself again if nothing changed. She asked mental health staff to review the woman.
53. Nurse J came to assess the woman, but could not complete an assessment as the woman was distressed and crying loudly. Nurse H spoke to SO A, who decided that it was not necessary to change the woman's location or

observations because she had not actually tried to harm herself that day, there was an ACCT case review scheduled for the next day and a psychiatric assessment was booked for the day after. However, managers decided that the woman would now have to be unlocked by two officers at all times because of the threats she had made about Officer A. Her regime was very limited during this period because of this measure and her need to be located in a safer cell.

### **Return to the healthcare unit from 26 November to 1 December**

54. On 26 November, staff including duty governor A, Nurse I, SO G and Nurse F held the fourteenth ACCT case review with the woman. They decided to move the woman back to a safer cell in the healthcare unit to remove any threat to Officer A and to ensure that the woman was nearer to the mental health team. The level of checks remained at four an hour. The woman moved back to the healthcare unit after an appearance by videolink at Newcastle Crown Court. Her case was adjourned for medical reports.
55. Two hours after she moved to the healthcare unit, Nurse I and Nurse G found the woman with bedding tied around her neck. This was removed and she recovered. Staff held a fifteenth ACCT case review and the woman was told that she had an appointment with a psychiatrist the next day. She remained in a safer cell with observation at four times an hour. After the review, Nurse C told the woman that anti-rip clothing would be the next step if she attempted to take her life again. (This is special clothing made out of material which is extremely difficult to tear into strips to create ligatures. Bedding is also made of the same material. This option was never used for the woman.) Dr B reviewed the woman's notes and prescribed lorazepam (to treat anxiety) in addition to mirtazapine and trazadone.
56. On 27 November, Dr C, the visiting psychiatrist, assessed the woman with Nurse I at her weekly clinic. The doctor recommended that the woman should transfer to a psychiatric unit where she would benefit from close nursing supervision and further diagnosis. She did not think that prison was a suitable location for her. The doctor recorded that she would discuss the transfer with the local psychiatric bed manager and the woman's care co-ordinator. She noted that she would review the woman a week later and asked the mental health team to continue to support her until a move to hospital could be arranged. The doctor continued the woman's prescription for lorazepam and recommended the continued use of ACCT monitoring in a safer cell. She supported the use of anti-rip clothing if staff at the next ACCT case review thought it was necessary.
57. SO G held the sixteenth ACCT review later that day. Nurse J, Nurse I and the woman were present. The review decided that the woman should remain in the healthcare unit safer cell with four observations an hour. Potential boredom was added as an issue to the ACCT care map and the woman was given magazines, jigsaws and a radio. Staff were told to check the radio regularly in case the woman tried to use parts of it to harm herself.



58. The same day, Nurse I contacted Greentrees Psychiatric Intensive Care Unit about a possible transfer for the woman. She was told that they did not accept remand prisoners. Dr B telephoned the psychiatrist bed manager and left a message for him.
59. On 28 November, Dr B left another message for the psychiatrist bed manager and asked Nurse I for contact details for the woman's care coordinator, and her legal representative. The same day, SO G, Nurse I, Nurse L and the deputy governor, B, attended the woman's seventeenth ACCT case review with other staff and the woman. They decided to keep the woman in the safer cell in the healthcare unit with the same frequency of observations and it was no longer necessary for two officers to unlock the woman. Later in the afternoon, the woman became very upset and banged her head against her cell door for several minutes.
60. On Friday 29 November, Dr B telephoned the woman's care co-ordinator about the woman. She found that the woman's care co-ordinator was out of the office until 3 December, so she sent an email asking her to contact her. Dr B also contacted Roseberry Park mental health unit in Middlesbrough to see if they had a bed available for the woman. They had no vacant beds and said that, as the woman was an 'out of area' referral, it would take longer to assess her.
61. The same day, the safer custody coordinator who had attended a number of the woman's ACCT case reviews) emailed SO G before the next case review with concerns about the possibility of the woman being moved out of the safer cell. She noted the woman's mood could change very quickly. The SO, deputy governor B and Nurse I and other staff attended the woman's eighteenth ACCT case review that afternoon, but the woman refused to attend and remained on her bed sobbing loudly. The review, chaired by deputy governor Br, decided to keep the woman in the healthcare unit safer cell and maintained the same level of observations.
62. Later that day, the woman told Nurse I that she wanted to go to sleep and not wake up. The nurse recorded this in the ACCT document, updated the woman's care plan in her clinical record and planned to review her on Monday 2 December, when the mental health team were next at work. The woman became upset that afternoon when she learnt that a neighbour who had looked after her pets until now was unable to care for them anymore and that the RSPCA would have to look after them. Nurse G spoke to the RSPCA on the woman's behalf.
63. The woman became upset and distressed during the night. The next morning, 30 November, the woman stayed in bed and initially showed no interest in getting up and having a shower. That morning, head of safer custody, the duty governor, chaired her nineteenth ACCT case review. Nurse C, the Reverend and the woman attended. No mental health staff were on duty that day and no one obtained advice from the duty mental health manager who was on call.

64. The head of Safer Custody had already consulted the deputy governor B about the woman's last two ACCT reviews. The deputy governor B had advised him that he had planned to move the woman out of the safer cell to a standard healthcare cell on 29 November, but had decided not to after learning that she had been banging her head against the cell door on 28 November. The duty governor B advised the head of Safer Custody to move the woman from the safer cell on 30 November if the woman did not harm herself again during the night and she presented well.
65. At the ACCT case review, the woman said that she felt very flat, but could not explain why. She said that she would try and talk to staff if she found her own thoughts too much to deal with. The review decided to move the woman from the safer cell to a standard healthcare cell because she had not self-harmed again. The level of checks remained at four times an hour. The woman was told that she would be moved back to the safer cell if she tried to harm herself again.
66. At about 7.30pm that evening, a healthcare support worker checked the woman, who asked her how frequently checks were being made, whether they were every 15 minutes and whether the healthcare support worker had a key to get into her cell if she needed to. The healthcare support worker asked the woman if she was feeling OK. The woman said that she was not, but she did not want to talk about it. She gave the healthcare support worker the name of her partner for her next of kin details, which she had previously declined to do. Because of the questions she was asking, the healthcare support worker was concerned about the woman's mood and reported the conversation to Nurse C, who was in charge of the healthcare unit at the time. The healthcare support worker noted the conversation in the woman's clinical record and the ACCT ongoing record and added the next of kin information to the woman's ACCT document.
67. Nurse C told the investigator that she handed over to L, who was working the night shift, and passed on what the healthcare support worker had told her. As an informal, temporary measure, Nurse L asked the nurse to make additional checks during the night (beyond the four checks an hour required under the ACCT process) and to keep a closer eye on the woman. The nurse did not make an entry in the ACCT document and did not formally increase the number of ACCT checks because she considered that the next step beyond four checks an hour was constant supervision, which she did not think was warranted.
68. At about 6.30am the next morning, Sunday 1 December, Nurse L, noted in the woman's clinical record that she had watched television until 10.00pm the previous evening before appearing to sleep through the night. The nurse had also made entries in the ACCT ongoing record.
69. Later in the day, the head of Safer Custody chaired the woman's twentieth ACCT case review. Nurse L, who was in charge of the healthcare unit that day, the reverend, Officer B and the woman attended. It was noted that the woman interacted well and again said that she would speak to staff if her thoughts became too much for her. The woman remained in a standard healthcare cell and was still being checked four times an hour. The next ACCT case review was scheduled for 4 December.

## 1 December

70. At about 4.00pm on Sunday 1 December, the health support worker spoke to the woman about her circumstances and the woman became upset. At 5.15pm, prisoners were locked up for the evening. Nurse L gave the woman her medication at approximately 6.00pm. Staff, in the healthcare unit use the cell bell system to record when they have carried out ACCT checks. They press the visit button outside a prisoner's cell at each check and this is recorded electronically. The electronic records show that at 6.12pm (the cell bell system appears to be six minutes behind real time, so the actual time this happened was at about 6.18pm) Nurse N performed a routine ACCT check on the woman, who was sitting on her bed watching television. She told the nurse that she was fine. The nurse recorded this check in the ACCT document at 6.20pm.
71. The main healthcare unit was fully staffed that day, but Nurse L, who would normally have remained on the healthcare unit, went to the prison's detoxification unit to issue medication as there was a shortage of staff in the substance misuse team. Nurse N and Nurse O left the healthcare unit as normal to issue medication in the main part of the prison. The healthcare support worker was now left alone in the healthcare unit for a short period. No officers are based in the healthcare unit after the prisoners have been locked up for the night.
72. The electronic records show that the healthcare support worker next checked the woman at 6.44pm. (Although the actual time was just before 6.50pm.) The records show that, although it had been 32 minutes since the previous check, the 6.50pm check was the fourth random check by staff within a 60 minute period, thus complying with the required frequency of ACCT observations. She opened the observation panel, but could not see the woman in the cell. The lights were switched off, so she called the woman's name a couple of times and kicked the door, but got no response.
73. Under local prison policy, the healthcare support worker was not allowed to enter the cell. During patrol state, healthcare staff have to ask prison officers to unlock and enter cells if they have concerns about a prisoner. At about 6.50pm, she radioed to request help. Nurse L had finished in the detoxification unit and had just arrived in the main treatment area to help the other nurses. She was with SO C, who was the orderly officer in charge of the prison at the time, and they both ran to the healthcare unit. Another officer, SO F, arrived just behind them. As the healthcare support worker had not indicated that there was a medical emergency, Nurse N and Nurse O stayed in the main prison and continued to issue medication.
74. When SO C and Nurse L arrived in the healthcare unit, they did not know exactly where the problem was, as the healthcare support worker had not given a cell location. However, they quickly realised that help was needed at the woman's cell on the upper floor. The healthcare support worker was waiting outside the cell. The SO looked through the observation panel, unlocked the cell door and went inside with the nurse. The woman was hidden behind the privacy curtain at the end of the cell. She had hanged

herself using a bed sheet and had used a wooden brick, which she had obtained from a puzzle set in the association area, to hold the sheet tight behind the closed window. Her body was wedged upright between the toilet, the wall and the window.

75. SO C supported the woman's weight and Nurse L cut the sheet from the window and then from the woman's neck. The SO, Nurse L and the healthcare support worker found it difficult to move the woman safely from behind the toilet, but with SO F's help they managed to move the woman onto the bed first and then onto the floor.
76. The woman vomited. Nurse L cleaned her airway and began cardiopulmonary resuscitation (CPR). She asked the healthcare support worker to collect the emergency medical response bag, oxygen and a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). SO F helped to perform chest compressions and, when the healthcare support worker returned, Nurse L gave the woman oxygen. Staff attached the defibrillator but the machine advised them not to administer a shock, so they continued to perform CPR.
77. At 6.56pm, six minutes after the healthcare support worker had first asked for assistance, SO C radioed to ask the control room to call an ambulance. She did not use an emergency medical response code. Two members of staff were in the control room and the gatehouse, which adjoin each other. They asked for more information as they knew from experience that the ambulance service would need more details. However, SO C only repeated that she needed an ambulance.
78. When the first member of staff in the control room spoke to the ambulance service operator, she asked for an emergency blue light ambulance, but the operator requested more information before prioritising the call. As she was unable to provide it, the operator said that they could only give the call a medium priority. She confirmed the address and that the patient was female. She and the second member of staff in the control room tried but were unable to get more information from staff at the scene.
79. Staff in the control room eventually transferred the ambulance service operator to SO C in an office in the healthcare unit. SO C confirmed the details again and explained that the woman had hanged herself, that they had removed the sheet she had used as a ligature and that they had started to attempt resuscitation. By this point, the ambulance was already nearly at the prison gates.
80. The first ambulance arrived at 7.05pm, followed by a rapid response vehicle at 7.12pm and another ambulance at 7.24pm. Paramedics went to the healthcare unit and took over the resuscitation effort. They took the woman to the University Hospital of North Durham, leaving the prison at 7.51pm. The woman was escorted by one officer and no restraints were used. Sadly, she did not recover and, with her parents' consent, her life support machine was switched off at 11.00am the next morning, 2 December.

81. Staff reviewed prisoners on open ACCT documents. The majority of staff who the investigator interviewed felt well supported by their managers and the prison's care team after the woman died.

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

82. After the woman was taken to hospital, the head of safer custody telephoned the Governor and the deputy governor. They thought that the woman did not have any next of kin details on her record although, the day before, her partner's details had been recorded in her ACCT document. The managers consulted SO C and decided that, based on her previous telephone conversation with the woman's mother, she would not want to be told about her daughter's hanging. The SO told the investigator she did not think that the woman's mother had meant that she did not want to speak to her daughter ever again, but that declining to allow her daughter to contact her by telephone at the time was just her way of coping with a difficult situation. Although the prison held a record of the woman's mother's telephone number, the senior managers decided not to contact her at that stage but to get in touch the next morning once they had more information from the hospital about her condition and prognosis.
83. Hospital staff decided to contact the woman's family themselves during the night and her relatives arrived at the hospital at 6.00am. The head of Safer Custody and the prison's family liaison officer went to the hospital to meet them before the woman's life support machine was turned off.
84. No further action had been taken over the weekend about the plan to transfer the woman to a psychiatric unit. A further meeting to discuss her transfer had provisionally been scheduled for 11 December.
85. In line with national Prison Service guidance, the prison contributed towards the cost of the woman's funeral, which was held on 12 December.

## ISSUES

### Clinical care

86. When the woman arrived at Low Newton, she had only just been discharged from a psychiatric hospital, after having a period of crisis when a relationship broke down. She had never been to prison before. The woman was difficult to manage and her moods were unpredictable, extreme and liable to change quickly. She made serious and determined attempts to hang herself. Each time she tied something around her neck, the knot was tight and healthcare staff were under no illusion that she planned to end her own life.
87. The clinical reviewer was impressed by the efforts of healthcare staff at the prison to support the woman. Nurse A immediately recognised the risk of suicide and took steps to keep her safe as soon as she arrived on 9 November. The mental health team manager, visited the prison the next day, a Sunday, to make an emergency mental health assessment. She quickly obtained the woman's community clinical records and established her recent history to help inform the management of her risk.
88. Healthcare staff were in no doubt from the time she arrived that the woman required very careful monitoring. They spoke to her care coordinator in the community, she was discussed at the mental health team meeting on 11 November and allocated a keyworker, Nurse D. The healthcare staff made contingency plans for the woman's ongoing community psychiatric care in case she was released on bail. They also contacted external agencies about her housing and pets to try to put her mind at rest, as these issues were causing her concern. The clinical reviewer found that assessments by primary care staff and the mental health team were comprehensive and well documented.
89. However, after the woman moved to the induction wing, the promised daily visits from her mental health keyworker with Nurse D, did not happen. The nurse was new to the mental health team and did not know that she was expected to arrange a handover with another member of the team to ensure continuity of care when she took leave. She went on two weeks leave from Friday 15 November and assumed that the woman's ongoing care would be picked up by a colleague at the daily team meetings. A week later, the oversight was discovered and Nurse I was then allocated as the woman's mental health keyworker. She then made an urgent referral to the visiting psychiatrist. While this oversight was regrettable, the woman continued to be managed closely under the ACCT process during this period and primary healthcare staff were alerted when wing staff needed them. While she appears to have had reasonable support, the woman herself drew attention to the fact that she was not seeing her keyworker as promised. The care from the mental health team should have been delivered as planned. We make the following recommendation:

**The Head of Healthcare should ensure that the mental health team deliver care as planned and that keyworker responsibilities are covered by another member of the team during staff absences.**

90. The woman was not referred to the visiting psychiatrist until 22 November, 13 days after she had arrived at Low Newton. In that time, she had attempted to hang herself a number of times and staff had received her community clinical notes and discharge summary outlining her psychiatric history. When Dr C assessed the woman at her next weekly clinic, she immediately began to arrange a transfer back to hospital. The doctor told the investigators that a hospital transfer would normally take at least ten working days, to arrange funding, an available bed, two medical reports endorsing the transfer and a warrant from the Ministry of Justice. Sadly, the woman died before the doctor and her colleagues could make significant progress, but we are satisfied that appropriate efforts were being made at the time of her death.
91. There is no clear reason in the woman's clinical record to explain why she was not immediately referred to a psychiatrist. Healthcare staff told the investigator that they had planned to allow the woman a couple of weeks to settle into prison life before she saw the psychiatrist, so that the psychiatrist could accurately assess her mood and ability to cope in prison. Dr C agreed that the clear evidence of the woman's failure to cope with prison when she assessed her on 27 November helped to strengthen her argument for a transfer.
92. The clinical reviewer thinks that the woman should have been referred to a psychiatrist as soon as possible because of her mood on arrival, her recent psychiatric history and because she was subject to the Care Programme Approach in the community. We agree that an immediate psychiatric assessment would have been helpful and might have resulted in earlier arrangements being made to seek a transfer to a psychiatric unit, a better place to care for the woman. We make the following recommendation:

**The Head of Healthcare should ensure that newly arrived prisoners who are subject to the Care Programme Approach in the community, or appear to be in crisis, have a prompt review by a psychiatrist to assess whether they require hospital treatment.**

## **Managing the risk of suicide and self-harm**

### **Constant supervision**

93. Prison Service Instruction 64/2011 requires that prisoners subject to constant supervision should be seen by a doctor once every 24 hours. The woman was constantly supervised from 9 to 12 November, but a doctor did not assess her at any time during that period. Dr B saw the woman on 12 November, but not until after the ACCT review panel had already ended constant supervision earlier in the day. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prisoners subject to constant supervision are checked at minimum every 24 hours by a doctor.**

## **Involvement of healthcare staff in the ACCT process**

94. Our interviews with both mental health and primary care nurses revealed a perception among this group of staff that their clinical opinion about how to keep the woman safe was sometimes marginalised by prison managers.
95. On 9 November, Nurse A recommended constant supervision for the woman. She said that this was the first time that she had recommended constant supervision for a prisoner, but that she was certain that the woman would try to kill herself. Despite this advice, SO A, SO B, Duty Governor A and the custodial manager A decided on four observations an hour in a standard cell. Within a few hours, the woman had tried to hang herself twice, which then prompted the Duty Governor to authorise constant supervision in a safer cell.
96. On 12 November, Nurse D voiced her concerns about the decision by the man chaired the woman's third case review and the ACCT panel to end constant supervision. She described the case review as 'intense' and recorded her misgivings in the clinical record. She had no doubt that the woman would continue to try to take her own life and believed that she had real intent to kill herself. The man who chaired the woman's third case review told the investigator that the panel had had a long discussion before ending constant supervision and that Nurse D's concerns had been addressed.
97. On 22 November, the woman made two attempts to hang herself in quick succession and was moved to a safer cell. Nurse G and Nurse I checked the woman and requested constant supervision because they felt that she was intent on attempting suicide. However, prison managers decided that frequent checks in a safer cell offered sufficient protection.
98. Nurse F attended the ACCT review on 22 November. After the frequency of observations remained unaltered, she decided to perform her own additional checks because she was certain that the woman planned to take her own life. She told the investigator that she thought that the woman was one of the most troubled women she had ever met and was waiting for the most opportune moment to hang herself.
99. On Saturday 30 November, the woman was moved from a safer cell without the input of the mental health team. Mental health staff do not work on weekends and therefore did not attend the ACCT reviews on Saturday 30 November or Sunday 1 December. The nurse in charge of healthcare (Nurse C on 30 November and Nurse L on 1 December), the heads of Safer Custody and the duty manager attended both reviews.
100. The head of Safer Custody wanted to remove the woman from the safer cell as soon as possible. He had spoken to the deputy governor, about the ACCT reviews he had chaired on 28 and 29 November and the duty governor had advised him to move the woman from the safer cell on Saturday 30 November if she did not harm herself again and if she presented well. The head of Safer Custody recalled that the woman had seemed much the same at the ACCT reviews on 30 November and 1 December, which he felt endorsed the decision to relocate her. Nurse C said that the decision to remove the woman from the safer cell was taken by the panel because she had not tried to hang



herself for several days. They thought that it was unreasonable for the woman to spend any more time in safer cell conditions. The duty governor explained that the ACCT review panel relocated the woman because access to a television in a standard cell would help improve her mood. He recalled that the woman was slightly happier at the review on 1 December, so those present at the review were satisfied that they were right to have moved her from the safer cell.

101. Mental health staff were concerned that they were not consulted about the decision to move the woman out of the safer cell. The healthcare manager, described the decision as a very important one to have been taken without the input of her team. She questioned why the woman could not have remained in a safer cell until the Monday, when all parties involved in her care could have contributed to the decision. Nurse I agreed. She had expected the woman to remain in the safer cell over the weekend based on her presentation on Friday 29 November.
102. It is concerning that mental health and primary care nursing staff perceive that their opinion is not always listened to, or given sufficient weight, especially when a prisoner has documented severe mental health issues and is under the care of the mental health team. The woman had been assessed as requiring a transfer to hospital and was therefore a priority for the mental health team. We believe that the mental health team should have been closely involved in any decisions about her. The clinical reviewer believes that mental health staff should have led the decision-making process for the woman's ACCT monitoring and should have been involved in any decision to move her out of the safer cell. We agree and make the following recommendation:

**The Governor and the Head of Healthcare should ensure that the mental health team are invited to attend or contribute to all ACCT reviews for prisoners under their care and are fully involved in any important decisions about their level of risk.**

#### **Enhanced case management**

103. Prison Service Instruction (PSI) 64/2011 recommends enhanced case management for those prisoners whose challenging behaviour requires more intensive input to manage their increased risk of suicide and self-harm. Such a prisoner will already be under the care of the mental health team and subject to ACCT procedures, might have spent time in the healthcare unit, repeatedly attempted to take her own life and been subject to constant supervision. She might have needed to be unlocked by more than one officer, might have committed discipline offences and might have represented a threat to staff. During her three weeks at Low Newton, the woman displayed all of these behaviours to a greater or lesser degree.
104. PSI 64/2011 states that enhanced case management can be very effective in reducing a prisoner's risk of harm to herself. The process requires that a custodial manager or a more senior manager chairs the case reviews. The multidisciplinary enhanced case review team should include a member of the mental health team (ideally the prisoner's keyworker) or a doctor, as well as other staff working with the prisoner, the manager of her residential unit, the

chaplain and a member of the Independent Monitoring Board. In exceptional circumstances, when a member of the enhanced case management team cannot attend, they should make a written contribution to a case review.

105. There were frequent ACCT case reviews, which were usually multidisciplinary and chaired by either a custodial manager or a higher grade of staff. However, there were too many different case managers, partly as a result of time spent on two different units and the need to hold a number of reviews at weekends and evenings. The woman was never actually subject to enhanced case management. While a great deal of what Low Newton staff did to manage the woman resembled enhanced case management, it was never formally implemented. The woman undoubtedly had complex needs and met the criteria for enhance reviews set out in the PSI. We think that staff should have used enhanced case management, which should have ensured, in particular, that the mental health team had some input into all of her case reviews and that important decisions were not taken without consulting the mental health team. We make the following recommendation:

**The Governor should ensure that staff are aware of and understand the enhanced ACCT case management approach and that is used appropriately for suicidal prisoners with complex needs.**

#### **ACCT care map**

106. The woman's ACCT care map was begun at the first ACCT case review after her assessment interview. SO A identified three issues: medication (which was prescribed and issued while the woman was in prison), mental health (the woman was referred to the mental health team) and contact with her partner (this issue was not resolved, presumably because her partner was the victim of her offence). Three further issues about accommodation and money worries were added at the fifth and eighth ACCT case reviews. The SO noted at a case review on 25 November that these issues had been addressed (although not apparently resolved). The SO seems to have been the only member of staff to have checked the care map regularly and used it as an interactive document that requires constant updating to help reduce the prisoner's risk to herself.
107. Prison Service Instruction 64/2011 requires the case review panel to update the care map to reflect any decisions made, consider a prisoner's progress against the initial care map actions and consider whether there are additional needs identified which require the care map to be updated. The issues on the care map should be dated to ensure that they are achieved within a specified timeframe. Above all, the care map must relate to the issues affecting the prisoner. After 25 November, there were no updates to the care map, even after the woman's mood deteriorated and she returned to the healthcare unit. When she died, staff had not updated the care map for nearly a week. There is no evidence that staff used the care map as an interactive document in the period before the woman's death. All of the issues were dated earlier in November and it is not clear what had been regarded as being achieved and what had yet to be done.
108. We accept that the woman had very complex needs which might not have been able to have been met in prison and she seems to have had a very

determined intention to kill herself. Nevertheless, we believe that more attention should have been paid to this part of the ACCT process, which is often neglected in cases this office investigates. Case managers sometimes unavoidably change and new case managers need to be able to see from the care map which issues are outstanding and what work needs to be done to reduce the prisoner's risk. Reference to care map objectives can also help engage the prisoner and reassure them that their needs are being taken seriously. We make the following recommendation:

**The Governor should ensure that:**

- **ACCT care maps have meaningful time-bound actions aimed at reducing prisoners' risks to themselves**
- **Progress against care maps is considered at each review and that care maps are updated if additional needs are identified**
- **ACCTs are not closed until all identified actions of care maps have been completed**

**Information about heightened risk and frequency of observations**

109. On the evening of 30 November, the healthcare support worker became concerned about the woman, who had asked how often she was being checked and whether she had a key to her cell. She also gave the healthcare support worker her next of kin details, something which she had previously declined to do. The healthcare support worker reported her concerns to Nurse C, who asked the nurse working the night shift to perform additional, informal checks. The nurse did not think that the new information warranted constant supervision, which she believed was the only escalation possible under the ACCT process and would have required the agreement of the operational manager in charge.
110. Because the frequency of ACCT observations remained unchanged (at least on paper), Nurse C did not record her thinking in the ACCT document. The woman's heightened risk (however temporary) was not considered or discussed at the next ACCT review and the case review panel does not appear to have discussed the healthcare support worker's entry in the ACCT ongoing record about what the woman had told her.
111. Nurse C could have held an immediate case review with the orderly officer on the evening of 30 November on the basis of what the healthcare support worker told her and it is evident that she had some concerns that the woman's risk had increased. We consider that she should have clearly recorded her views in the ACCT document and the fact that she had asked the nurse on duty that night to make temporary additional checks. In theory this ought to have helped the case review the next day make a more informed assessment of risk, but we note that there is no evidence that the case review noted or took into account the comments that the healthcare support worker had entered about her concerns. As reviews were being held daily, we would have expected the case review to have read and noted entries in the ongoing record to help inform their decisions about the woman's level of risk.
112. At the time she was found hanging on 1 December, the woman was regarded as a high risk of suicide and required to be checked four times an hour at

random intervals. When the healthcare support worker raised the alarm, she was on her own in the healthcare unit and it had been 32 minutes since the woman had last been checked. While this technically fulfilled the requirement for four checks an hour, we consider that an interval of this length between checks is too long for prisoners at this level of risk. We make the following recommendations:

**The Governor and the Head of Healthcare should ensure that whenever there is information suggesting a woman on an open ACCT is at increased risk, there is full consideration of all the options, that action is taken and that this is recorded in the ACCT documentation and considered at the next case review.**

**The Governor and Head of Healthcare should ensure that intervals between ACCT observations appropriately reflect the assessed risk of the woman prisoner.**

### **Emergency response**

113. The response when the woman was found hanging in her cell was not as rapid or well coordinated as it should have been. The healthcare support worker was working alone in the healthcare unit when she looked through the observation panel and could not see the woman. Because she was alone, she did not enter the cell immediately in spite of her concerns, but radioed for help.
114. We are concerned that even though healthcare staff have cell keys which would allow them to enter a cell immediately in an emergency, they have been instructed not to go into a cell unless there is an officer present. Entering a cell alone requires the member of staff to make an individual risk assessment and it is possible that the healthcare support worker would have concluded in these circumstances that it was not safe, particularly as she had been left alone on the unit. In the circumstances, as nurses had been required to help out with dispensing medication elsewhere, it would have been prudent to deploy an officer to the healthcare unit for that period. As there are generally no officers present on the unit during the patrol state when prisoners are locked in their cells (the current arrangements at Low Newton), this means there is no possibility of immediate action in a life-threatening situation involving a woman in a locked cell at those times. As the healthcare unit sometimes holds very vulnerable women at risk of suicide, like The woman, we do not consider that the current arrangement is adequate to protect very vulnerable women. We make the following recommendation:

**The Governor should ensure that there are safe procedures to allow staff working in the healthcare unit, subject to an individual risk assessment, to enter a cell immediately in a life-threatening situation.**

115. The healthcare support worker did not call a code blue emergency, because she could not tell if it was a life-threatening incident and did not give a cell location, so staff were unaware of exactly where help was needed when they arrived on the healthcare unit. Although control room staff had heard messages on the radio network, they did not call an ambulance at this stage because there was nothing to indicate a life-threatening situation.

116. After staff found the woman hanging, there was a breakdown in communication with the control room staff. None of the staff at the scene used the proper emergency code in accordance with Prison Service Instruction 03/2013 'Medical emergency response codes', which was implemented at Low Newton on 21 March 2013 in Staff Information Notice 28/13. All staff should have known what to do in an emergency, as they had been issued with a credit card-size document which reminded them of the changes in the new instruction. Nurse L thought that no one used the emergency code because healthcare staff were already at the scene when the woman was discovered hanging. However, the use of a code dictates the response of the control room staff as well as healthcare staff. An emergency code would also have alerted other healthcare staff to come and assist.
117. There was a gap of six minutes between the healthcare support worker asking for assistance and SO C asking for an ambulance to be called. This should have been done immediately and an ambulance would have been called automatically had the appropriate emergency response code been used. It appears that, as the woman had previously recovered quickly after other attempts at hanging, the staff tried to resuscitate her before requesting an ambulance, thinking that she would recover as she had done before.
118. When SO C asked for an ambulance over the radio, she did not use an emergency code or provide any other details to the control room staff, despite their requests. This meant that control room staff did not have the details they needed, which in turn led to a delay in the dispatch of an emergency ambulance. There was no protocol with the North East Ambulance Service which might have helped them understand the prison context and avoid such misunderstandings. PSI 03/2013 requires the prison's emergency response protocols to be written in conjunction with the local health commissioner and the local ambulance trust. It does not appear that this was done and nor does it appear that staff at Low Newton understood the importance of adhering to the emergency code procedures. We accept that the prison has issued guidance, but the evidence of this emergency is that it is yet to be embedded. We make the following recommendations:

**The Governor should ensure that all prison staff are reminded of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Low Newton has a Medical Emergency Response Code protocol agreed with the local ambulance service which:**

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances**

### **Family liaison**

119. The woman did not nominate a next of kin when she arrived at Low Newton on 9 November, but the prison had contact details for her mother as SO C spoke to her on 11 November to check if she wanted to receive calls from her

daughter. On 30 November, The woman gave the details of her partner, which were added to the ACCT document next of kin section.

120. After the woman was taken to hospital on 1 December, the head of Safer Custody telephoned the governor and the deputy governor to discuss notifying her family. They agreed not to contact the woman's mother for the time being and assumed from SO C account of her telephone call several weeks earlier that the woman's mother did not want anything more to do with her daughter. This had not been the SO's interpretation. The deputy governor told the investigator that the managers had decided to wait until the next morning to get a clearer picture of the woman's condition before contacting her family. The woman's partner's details in the ACCT document were not used because she had had recent relationships with two women and there was confusion over which one had been the victim of her offence.

121. Prison Rule 22, about the notification of illness or death, states:

“If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.”

122. We do not consider that the woman's mother's decision several weeks earlier about whether her daughter should be allowed to contact her by telephone should have been a factor in informing her parents when the woman was taken to hospital. Her parents should have been notified immediately, in line with Prison Rule 22. We make the following recommendation:

**The Governor should ensure that a prisoner's next of kin is informed at the earliest opportunity following an emergency admission to hospital.**

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that the mental health team deliver care as planned and that keyworker responsibilities are covered by another member of the team during staff absences.
2. The Head of Healthcare should ensure that newly arrived prisoners who are subject to the Care Programme Approach in the community, or appear to be in crisis, have a prompt review by a psychiatrist to assess whether they require hospital treatment.
3. The Governor and Head of Healthcare should ensure that prisoners subject to constant supervision are checked at minimum every 24 hours by a doctor.
4. The Governor and the Head of Healthcare should ensure that the mental health team are invited to attend or contribute to all ACCT reviews for prisoners under their care and are fully involved in any important decisions about their level of risk.
5. The Governor should ensure that staff are aware of and understand the enhanced ACCT case management approach and that is used appropriately for suicidal prisoners with complex needs.
6. The Governor should ensure that:
  - ACCT care maps have meaningful time-bound actions aimed at reducing prisoners' risks to themselves
  - Progress against care maps is considered at each review and that care maps are updated if additional needs are identified
  - ACCTs are not closed until all identified actions of care maps have been completed
7. The Governor and the Head of Healthcare should ensure that whenever there is information suggesting a woman on an open ACCT is at increased risk, there is full consideration of all the options, that action is taken and that this is recorded in the ACCT documentation and considered at the next case review.
8. The Governor and Head of Healthcare should ensure that intervals between ACCT observations appropriately reflect the assessed risk of the woman prisoner.
9. The Governor should ensure that there are safe procedures to allow staff working in the healthcare unit, subject to an individual risk assessment, to enter a cell immediately in a life-threatening situation.
10. The Governor should ensure that all prison staff are reminded of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Low Newton has a Medical Emergency Response Code protocol agreed with the local ambulance service which:
  - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
  - Ensures staff called to the scene bring the relevant equipment; and

- Ensures there are no delays in calling, directing or discharging ambulances

11. The Governor should ensure that a prisoner's next of kin is informed at the earliest opportunity following an emergency admission to hospital.



No	Recommendation	Accepted / Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that the mental health team deliver care as planned and that keyworker responsibilities are covered by another member of the team during staff absences.	<b>Accepted</b>	The Head of Healthcare in partnership with the Mental Health providers has now ensured that the interventions prescribed are carried out as per the care plan to include all staff absences from the establishment.	<b>Completed</b>	
2	The Head of Healthcare should ensure that newly arrived prisoners who are subject to the Care Programme Approach in the community, or appear to be in crisis, have a prompt review by a psychiatrist to assess whether they require hospital treatment.	<b>Accepted</b>	The Head of Healthcare in partnership with the Mental Health providers will devise a protocol to ensure those on Care programme approach or in crisis will receive appropriate access to psychiatric assessment in line with current contractual arrangements.	<b>AUG 14</b>	
3	The Governor and Head of Healthcare should ensure that prisoners subject to constant supervision are checked at minimum every 24 hours by a doctor.	<b>Accepted</b>	A Local protocol is currently in place which ensures Monday to Saturday cover by Doctors. If a Doctor is not in the establishment on a Sunday a Senior Clinical practitioner would see the prisoner in the doctors absence. If any concerns are raised the on call locum Doctor would be contacted to come into the establishment to see the prisoner.	<b>Completed</b>	
4	The Governor and the Head of	<b>Accepted</b>	The Governor and the Head of Healthcare in partnership	<b>JULY 14</b>	

	Healthcare should ensure that the mental health team are invited to attend or contribute to all ACCT reviews for prisoners under their care and are fully involved in any important decisions about their level of risk.		<p>with the Mental Health providers have a current arrangement in place ensuring Mental Health cover Monday – Friday with on call arrangements for week ends and Bank holidays.</p> <p>The Governor and the Head of Healthcare in partnership with the Mental Health providers will ensure that Mental Health staff are given access to the case review diary to give them an opportunity to schedule / prepare for any upcoming reviews. If a mutual convenient time can not be accommodated a written or verbal input will be supplied by the Mental Health team which will be appropriately documented on the case review notes.</p> <p>An approach will be made to the commissioners for provision for 7 day cover which would result in a contractual change.</p>	<p><b>JULY 14</b></p> <p><b>DEC 14</b></p>	
5	The Governor should ensure that staff are aware of and understand the enhanced ACCT case management approach and that is used appropriately for suicidal prisoners with complex needs.	<b>Accepted</b>	The Governor will instruct the Head of Safer Custody to issue guidance to managers to ensure they are fully aware of how to conduct / implement Enhanced case reviews.	<b>JULY 14</b>	
6	The Governor should ensure that: a)ACCT care maps have meaningful time-bound actions aimed at reducing prisoners' risks	<b>Accepted</b>	The Governor will instruct the Head of Safer Custody to issue written guidance to managers to ensure care maps are appropriately updated at all case reviews, evidencing that item's discussed from care maps are annotated in the case review, that actions are time bound and that	<b>JULY 14</b>	

	<p>to themselves</p> <p>b)Progress against care maps is considered at each review and that care maps are updated if additional needs are identified</p> <p>c)ACCTs are not closed until all identified actions of care maps have been completed</p>		<p>ACCT documents are not closed until all identified actions are completed. The Safer Custody monthly quality checks have been adapted to include compliance with care maps. The outcomes of these checks will be circulated to all managers as well as discussed at the monthly Safer Custody meeting as part of a standing agenda.</p>		
7	<p>The Governor and the Head of Healthcare should ensure that whenever there is information suggesting a woman on an open ACCT is at increased risk, there is full consideration of all the options, that action is taken and that this is recorded in the ACCT documentation and considered at the next case review.</p>	<b>Accepted</b>	<p>The Governor and the Head of Healthcare will ensure that further guidance and learning points will be disseminated to staff on the best practice of recording in the ACCT document and Clinical Record ensuring all appropriate information is disclosed.</p>	<b>Jul 14</b>	
8	<p>The Governor and Head of Healthcare should ensure that intervals between ACCT observations appropriately reflect the assessed risk of the woman prisoner.</p>	<b>Accepted</b>	<p>The frequency of observations will appropriately reflect the assessed risk of the prisoner in line with the case review recommendations.</p>		
9	<p>The Governor should ensure that there are safe procedures to allow staff working in the healthcare</p>	<b>Accepted</b>	<p>The Governor will instruct the Head of Safer Custody to re-issue to all staff guidance on entry to cells in patrol state.</p>	<b>AUG 14</b>	

	unit, subject to an individual risk assessment, to enter a cell immediately in a life-threatening situation.		<p><i>Under normal circumstances, authority to unlock a cell during patrol states must be given by the Orderly Officer (OO) and no cell will be opened unless a minimum of two members of staff are present .</i></p> <p><i>Where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the OO and an individual member of staff may enter the cell on their own.</i></p> <p><i>Staff have a duty of care to prisoners and to themselves and to other staff. The <b>preservation of life</b> must take precedence over security concerns but patrol staff should not take action that they feel would put themselves or others in unnecessary danger.</i></p>		
10	<p>The Governor should ensure that all prison staff are reminded of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Low Newton has a Medical Emergency Response Code protocol agreed with the local ambulance service which:</p> <p>a)Provides guidance to staff on efficiently communicating the nature of a medical emergency;</p> <p>b)Ensures staff called to the scene bring the relevant equipment; and</p>	<b>Accepted</b>	<p>The Governor will instruct the Head of Safer Custody to re-issue guidance to all staff on the medical emergency procedures out lined in PSI 03/2013.</p> <p>Training sessions to be undertaken with all staff fully clarifying the emergency procedures out lined in PSI 03/2013.</p>	<p><b>JULY 14</b></p> <p><b>DEC 14</b></p>	

	c)Ensures there are no delays in calling, directing or discharging ambulances				
11	The Governor should ensure that a prisoner's next of kin is informed at the earliest opportunity following an emergency admission to hospital.	<b>Accepted</b>	Learning points have been drawn from this incident and will be fully discussed at the next Senior Management Team meeting. This will be enforced via our DIC contingency plans to ensure compliance.	<b>JULY 14</b>	