

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a woman, in July 2014,  
while a prisoner at HMP Holloway.**

## ***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 July 2014 after being found hanged in her cell at HMP Holloway the previous day. I offer my condolences to the woman's family.

A clinical reviewer was appointed to review the clinical care that the woman received at the prison. Holloway cooperated fully with the investigation.

The woman was sent to Holloway on 30 May 2014. She had been in the prison before and staff immediately began suicide and self-harm prevention procedures because of her current risk and previous history of self-harm. She initially lived in the dedicated detoxification unit and had treatment for alcohol withdrawal before moving to a residential unit. She was supported by a substance misuse worker during her time at the prison but she did not meet the criteria for care from the mental health team. Although she continued to harm herself occasionally, prison staff did not consider she was at high risk of suicide. The woman tended to be impulsive and staff frequently withdrew privileges because of her behaviour.

After an altercation, the woman received threats from other prisoners, but staff handled the situation well and kept her safe. The woman also claimed to have had a relationship with a prison officer at Holloway, although the investigation found no evidence to support this allegation. On 21 July, a manager intended to speak to the woman about the matter and she was locked in her cell that afternoon, instead of attending her usual activities. However, before the manager arrived, other prisoners found her hanged in her cell. She was taken to hospital but did not recover.

The woman could be a challenging young woman to manage and was regarded as a risk of self-harm throughout her time at Holloway. Nevertheless, I consider it would have been difficult for staff to have predicted her actions on 21 July. She was due to be released from prison three days later and was apparently looking forward to seeing her family.

However, the investigation identified some concerns about the operation of suicide and self-harm prevention procedures. In particular, case reviews were inconsistently chaired, risk assessment was often poor, recording required improvement and, while the woman received satisfactory clinical care, it is worrying that she was allowed to have a supply of sleeping tablets on which she attempted to overdose.

Although the woman received speedy emergency treatment, staff did not follow the expected emergency procedures for an unconscious prisoner and this could be crucial in a future emergency.

The 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**

**March 2015**

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## SUMMARY

1. The woman had a history of substance misuse and harming herself, usually by cutting. She had served a number of short sentences at HMP Holloway, during which she had been managed under Prison Service suicide and self-harm prevention procedures, known as ACCT. On 30 May 2014, she was sentenced to 16 weeks in prison for assaulting her mother. When she arrived at Holloway, staff immediately began ACCT procedures. Initially, staff monitored and treated her for symptoms of drug and alcohol withdrawal in the dedicated detoxification unit, before she moved to standard prison accommodation.
2. Officers referred the woman to the mental health team twice, once just after she arrived and again when her release date was approaching. Both times the team decided she did not meet their criteria. However, she was prescribed an antidepressant. A substance misuse worker supported her during her time at the prison and a housing worker helped arrange accommodation for after her release.
3. The woman cut herself a number of times and in early July, took an overdose of six sleeping tablets. Staff held 14 ACCT case reviews and assessed her as being at low risk of suicide and self-harm every time despite the frequent incidents of self-harm. The woman's behaviour was regarded as poor and she lost privileges. Managers considered the impact of the loss of privileges and her vulnerability at ACCT reviews. Although the woman's time out of her cell was restricted, she was still able to go to activities.
4. Prison staff intervened appropriately in an incident when it appeared that the woman was being bullied and kept the women concerned away from her for the remainder of her sentence. The woman told staff and prisoners that she was having a relationship with a prison officer. The prison investigated this after her death but found no evidence to substantiate the allegation. We found no further evidence to suggest it was true.
5. On the afternoon of 21 July, officers kept the woman in her cell so that a manager could speak to her about the allegations she had made about her relationship with the officer. She was tearful but an officer calmed her and checked her a little while later. Shortly afterwards, another prisoner found she had hanged herself. Staff administered emergency treatment and she was taken to hospital, where she died the next day.
6. The investigation found that ACCT procedures were not always completed in line with national guidance. There was little continuity of case managers, case reviews were not always multidisciplinary, risk assessments did not reflect changes in the woman's circumstances and her caremap did not include all relevant issues. On the day she was found hanging, staff did not record information about her risk in the ACCT document. However, we consider it would have been difficult to foresee her actions.
7. While the woman received good clinical care, we are concerned that she was allowed sleeping tablets in possession without a risk assessment, despite being regarded as at risk of suicide and self-harm. The emergency response

on 21 July was swift, but staff did follow the expected local and national guidance. We make three recommendations.

## THE INVESTIGATION PROCESS

8. One of our investigators, issued notices to staff and prisoners at HMP Holloway about the investigation. No one responded. The investigator visited Holloway on 25 July and collected copies of the woman's clinical and prison records. On 31 July, 14 and 19 August and 5 September, the investigator and a colleague interviewed prisoners and members of staff. The investigator informed the Governor of the initial findings of the investigation.
9. A clinical reviewer was appointed to review the woman's clinical care at the prison.
10. We informed HM Coroner for City of London of our investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this report.
11. One of our family liaison officers contacted the woman's mother to explain the investigation process. Her mother had no specific additional issues which she wanted of the investigation to take into account.

## **HMP HOLLOWAY**

12. HMP Holloway is a prison for women in north London which serves courts across the south east of England. It holds approximately 500 women in single and double cells and multi-occupancy dormitories. Central & North West London NHS Foundation Trust provides healthcare services.

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

13. HM Inspectorate of Prisons most recently inspected Holloway in June 2013. Inspectors commented that Holloway is a difficult prison to manage because of its size and design. However, although they found some significant shortcomings, they noted that this was the most positive inspection they had yet made of Holloway.
14. Inspectors found that the safer custody team was robust in managing anti-social behaviour and bullying and had a good understanding of the issues. However, in their survey, more women than in comparator prisons said that they felt unsafe. Levels of self-harm had decreased since the last inspection. On average, each month staff began ACCT suicide and self-harm procedures 46 times, there were 63 incidents of self-harm and the safer custody team received 25 violence report forms. Inspectors identified a need for better continuity of case manager at ACCT case reviews and more multidisciplinary case reviews. There was good support for vulnerable women whose behaviour was difficult and staff took into account whether sanctions were appropriate before using the Incentives and Earned Privileges scheme to challenge problematic behaviour.

### **Independent Monitoring Board**

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. The IMB commented in their 2013 annual report that Holloway was a safe and decent prison. They also believed that the incentives and earned privileges (IEP) scheme had been used effectively to manage difficult behaviour. The board had seen a marked increase in the quality of ACCT entries and care-maps following the delivery of staff training.

### **Previous deaths**

16. The woman's death was the first apparently self-inflicted death at Holloway since 2007.

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

17. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-



disciplinary reviews should be held. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

### **Incentives and Earned Privileges (IEP) scheme**

18. Prison IEP schemes aim to encourage and reward responsible behaviour through the award of greater privileges where a prisoner has been compliant with the prison regime and has engaged in work, education or other constructive activity. Similarly, these privileges can be removed if their behaviour deteriorates. There are four regime levels:

- Enhanced regime – the highest level;
- Standard regime;
- Basic regime - the lowest ranking with the least level of privileges;
- Entry regime - new prisoners begin on this level.

## KEY EVENTS

19. The woman had served a number of short prison sentences at Holloway. She had previously been managed under ACCT suicide and self-harm procedures twice in February 2011, once between August and September 2011, once between October and November 2012 and twice in December 2013 and in January 2014. Staff usually began ACCT monitoring because the woman cut herself, but she also reported using or considering other methods of harming herself in the community, such as by overdosing and planning to jump in front of a train. In November 2013, while at Holloway, she had been assessed as possibly having a personality disorder. She had been considered as suitable for a therapeutic programme except she was not serving a long enough sentence to be able to complete it.
20. On 30 May, the woman was sentenced to 112 days in prison for assaulting her mother. A court custody officer completed a suicide and self-harm warning form, noting that the woman was depressed and had current thoughts of self-harm. The officer noted that she had previously taken an overdose and slashed her wrists and, when arrested, she had head-butted a wall. The custody officer noted that the woman said that a prisoner now at Holloway had previously kidnapped and assaulted her and had tried to inject her with heroin.
21. The court custody officer completed the woman's Person Escort Record (PER). (The PER accompanies all prisoners as they transfer between police stations, courts and prisons and includes information about their risk of suicide and self-harm.) The officer wrote that the woman had self-harmed that month, was dependent on alcohol and suffered from depression, post-traumatic stress disorder and 'split personality'. The officer also highlighted the nature of the woman's offence.
22. The woman arrived at Holloway at 5.15pm. In reception, she gave her mother's contact details as her next of kin. Staff noted numerous self-harm scars. Officer A interviewed the woman and, at 6.30pm, began ACCT procedures. The officer recorded the woman's recent overdose, very low mood and that she said that she had been bullied during a previous prison sentence at Holloway. She referred the woman to the mental health team. The officer also completed a cell sharing risk assessment (CSRA), assessing the woman as a standard risk to other prisoners, meaning she was suitable to share a cell.
23. Custodial Manager A completed an ACCT immediate action plan. She required staff to observe the woman hourly and record three conversations with her during the day and one at night. She recorded two possible triggers that might cause the woman to self-harm: being bullied and arguing with others.
24. A healthcare assistant and prison Dr A saw the woman in reception. The woman said that she misused drugs and alcohol and gave a positive urine test result for cocaine and cannabis. She said that she suffered from depression and was prescribed sertraline (an antidepressant) in the community. The doctor recorded minor concerns about suicide and self-harm and assessed the woman's mental health problems as mild. The woman was

admitted to the dedicated detoxification unit to be monitored for symptoms of withdrawal from drugs or alcohol. She was not prescribed any medication for withdrawal symptoms at this stage and nurses did not observe any withdrawal symptoms overnight.

25. On 31 May, Officer B completed the woman's induction. Nurse A completed her second day health screen. The woman did not have any withdrawal symptoms and the nurse planned to discharge her from the unit after a further three days of observations.
26. At 2.30pm, SO A interviewed the woman for an ACCT assessment. The woman said that she had recently taken an overdose, while under the influence of alcohol, after an argument with her boyfriend. However, she was glad to have survived and said she did not have any current thoughts of suicide or self-harm. She said that she had been bullied in the past and asked for support. She was upset about assaulting her mother, with whom she had a difficult relationship. The woman identified three reasons for living: her boyfriend, her mother and her plan to do a college course. The woman was keen to detoxify from alcohol. The SO did not observe any withdrawal symptoms. She recommended that the woman should continue to be monitored under ACCT procedures.
27. At 4.15pm, SO B and Nurse A held the first ACCT case review. The woman said that she suffered from depression but was reluctant to take her medication. The staff encouraged her to take it. The woman asked for a single cell because she had been bullied before at Holloway, but she remained in a dormitory. The SO assessed the woman's risk of suicide and self-harm as low and required staff to observe the woman at least hourly and record a summary of their contact with her in the morning, afternoon and evening, and also have two conversations with the woman during the day and one at night. The SO drew up the woman's ACCT caremap and identified five issues:
  - Accommodation upon release
  - To complete gym and education induction
  - Location with a friend on B4 residential unit for support
  - Consideration of a single cell due to past bullying
  - To prevent self-harm, the woman was not to be issued with razors.
28. That evening, the woman began to take sertraline. She did not have any obvious withdrawal symptoms.
29. On the evening of 1 June, the woman made scratches to her hand. On 2 June, the woman told Dr B that she had first self-harmed at the age of 14 and drank alcohol until she passed out about four times a week. The doctor prescribed thiamine and vitamin B compound tablets (to treat the effects of alcohol misuse). The woman did not want her sertraline prescription increased. The same day, the mental health team discussed the woman at their weekly referral meeting. They noted her history of depression, substance misuse and self-harm by cutting. They concluded that the woman did not need to be accepted onto their case load but should continue to be managed by primary healthcare staff and engage with the substance misuse team.

30. Later on 2 June, SO C chaired the second ACCT case review with a member of staff from the substance misuse team present. The woman could not explain why she had made the scratches on her hand but said she felt isolated. She said that she had been the victim of an attempted rape by a drug dealer just before she had been sent to prison and she was scared about what would happen when she was released. The staff did not make any referral about this newly-identified issue or add it to the caremap as an issue to be addressed. The woman said she was keen to engage with a substance misuse support worker but this was not added to the caremap. In line with the issues already identified in her caremap, the SO referred her to the resettlement department to discuss housing options for when she was released and moved her to a dormitory where she was able to be supported by a friend. The review panel assessed the woman's risk as low.
31. On 3 June, the woman complained of vomiting, shaking, feeling hot and cold and a headache. Dr B prescribed chlordiazepoxide (for alcohol detoxification), metoclopramide and domperidone (to relieve nausea and vomiting), hyoscine butylbromide (for cramps) and paracetamol.
32. That afternoon, the woman's case worker from the substance misuse support and guidance service, assessed her. The woman said that she had misused cannabis, ecstasy, cocaine, amphetamines, heroin, crack cocaine and alcohol, had deliberately overdosed in the past and was only drug-free when she was in prison. The woman told the case worker that she had had enough of her lifestyle.
33. On 5 June, officers gave the woman a razor, although the ACCT caremap instructed them not to do so. She gave it back to them and said that she did not trust herself with it. On 6 June, the woman's case worker reviewed her. On 7 June, the woman gave staff the names of other prisoners who she claimed were planning to smuggle drugs into prison. Afterwards, she was worried that these prisoners would find out, but officers reassured her that this would not happen. On 8 June, the woman completed her five day chlordiazepoxide detoxification programme but said she was still suffering from alcohol withdrawal symptoms. On 9 June, Dr A prescribed a further five day programme.
34. At 12.20pm on 9 June, the woman became extremely tearful and told staff that she 'didn't want to be here anymore' and 'wanted to hurt herself'. She also said that she was finding it hard to share with one of the women in her dormitory. At 2.45pm, SO D chaired the third ACCT case review with Nurse A attending. The woman explained that she cut herself as a form of release and said that she had been raped before coming to prison (she had previously said this was an attempted rape). She said that she had put herself in a vulnerable position because of her lifestyle and did not want to report the rape to the police. The review panel assessed her risk of suicide and self-harm as low and maintained the same frequency of observations. The SO told the investigator that she had completed a handwritten referral to the Women in Prison team because the woman said she had been raped. She did not add this to the ACCT caremap as an issue to be addressed. Women in Prison is a charitable organisation that gives women prisoners and ex-offenders advice

about housing, mental health, benefits and other issues. They have a team working in Holloway. The team have no record of the SO's referral.

35. At 6.45pm that evening, the woman told SO D that she had cut her left arm using a razor. It is not clear where she got the razor from. A nurse treated the cuts. At 7.10pm, the SO and Nurse A held a fourth ACCT case review with the woman. She said that she had cut herself to relieve stress after her boyfriend had threatened to kill himself. The SO arranged for her to speak to him so that she could check how he was. SO D did not record the woman's level of risk of suicide or the frequency of observations on the ACCT document, but told the investigator that these had stayed the same as previously.
36. On 11 June, the woman's case worker reviewed her. On 12 June, the woman had a heated argument in the dormitory with one of the other women about which television channel to watch. The woman behaved aggressively and banged on the cell door. She asked to be let out and said that otherwise she would strangle the other woman. Staff moved them to separate dormitories and reduced the woman's IEP status from entry level to the basic regime for seven days. Because of this decision, SO E and a nurse held a fifth ACCT case review. The woman said that she would cope with seven days of the basic regime. The review assessed her risk of suicide and self-harm as low and maintained the same frequency of hourly observations.
37. On 13 June, the woman completed her second period of alcohol detoxification. Healthcare staff did not observe any further withdrawal symptoms. The same day, staff gave her two IEP warnings for bad behaviour. The woman complained that another prisoner was teasing her about being placed on the basic regime and SO E mediated between the two women and resolved the matter.
38. On 15 June, the woman told a nurse that she sometimes had seizures. The nurse referred her to a doctor. On 17 June, the woman was tested for sexually transmitted diseases because she had said she had been raped.
39. On 18 June, SO F chaired a sixth ACCT case review with a nurse and the woman's case worker. The woman said that she felt supported by the other women in her dormitory. Although she occasionally thought about harming herself, she said she tried to keep herself busy. She was worried that she might be epileptic and was waiting for a doctor's appointment about this. The review assessed her risk as low and maintained hourly observations. The SO added a sixth issue to the ACCT caremap, for the woman to see a doctor about her possible epilepsy. (Some of the caremap actions were now marked as complete.) The review considered the woman's IEP status and decided to keep her on the basic regime for a further seven days because she had received two further IEP warnings.
40. On 19 June, the woman saw Dr C about her concerns that she might have epilepsy. The doctor advised her about how to keep herself safe and suggested she go to her community GP to be referred to hospital after she was released in July, because she was serving too short a sentence to make a hospital referral from prison practical. The doctor prescribed diazepam

suppositories for nurses to administer as required if the woman had any more seizures.

41. Later on 19 June, the woman approached an advisor from the Women in Prison team for advice and said she was anxious about her forthcoming release. The team had not previously worked with her during this sentence. Later, the woman became very tearful and said that she was finding it hard to be in prison. She had a seizure and a nurse administered rectal diazepam. The next day, staff arranged for the woman to share with a new cellmate who could alert staff if she had any further seizures.
42. While the woman was living on the detoxification unit, a member from the programmes team saw her. He knew the woman from her previous sentence. the woman told him that she was surprised that no one from the mental health team had seen her. He agreed to check this for her.
43. At an IEP review on 23 June, SO E increased the woman's IEP status from basic to standard. The same day, Dr D prescribed further thiamine and vitamin B compound. Later, the woman made some superficial cuts to her upper left arm. Also that day, the advisor from the Women in Prison team, who the woman had spoken to a few days before, referred her to the Thyme Domestic and Sexual Violence Project. A Women in Prison worker tried to see her twice after that but no further progress was made with this referral.
44. On 24 June, SO D and Nurse A held a seventh ACCT case review. The woman could not explain why she had self-harmed the day before. The SO and the nurse agreed that she should now move to B4 residential unit, standard prison accommodation. The woman was unhappy about the move but the staff considered it was in her best interests. They assessed her risk as low. The woman's case worker went to check on the woman before she was discharged, and said that she was a little tearful about leaving the detoxification unit but seemed happy after she reached B4 unit. On 25 June, the woman's case worker went to see the woman again and thought that she seemed to be settling down.
45. On 26 June, SO A held an eighth ACCT case review with the woman. No other member of staff was present. The woman was distressed because she had just had an argument with her mother on the telephone. However, she said that she had no thoughts of harming herself. The SO assessed her risk as low and reduced the frequency of observations to every two hours.
46. The same day, the member of staff from the programme's team told the woman that she was not on the mental health team's caseload. She asked to be referred to the prison's day centre for women with mental health problems and he said he would check whether she was eligible. Later, the woman's case worker reviewed the woman who said that she was looking forward to being released and starting a new, drug-free life. Afterwards, a St Mungo's housing worker told the woman that she would be able to move into hostel accommodation in Clacton-on-Sea when she was released.
47. On 30 June, the woman received an IEP warning for ignoring an officer's instructions and was again placed on the basic regime for seven days. On 1 July, Dr D, a GP, saw the woman, who said that she was still having seizures.

The doctor referred her to a neurologist, advised her how to take precautions in the meantime and prescribed promethazine hydrochloride (sleeping tablets).

48. At 5.20pm on 1 July, the woman told SO G that she had stuck a drawing pin in her hand. The SO recorded in the ACCT document that he had not held an ACCT case review as he considered that the incident was 'not a major event and was a one-off'. A nurse checked the woman but there was only a small mark on her hand. A night patrol officer offered the woman the Samaritans telephone and access to a Listener (a prisoner trained by the Samaritans to support other prisoners), but she declined both.
49. At 3.20pm on 2 July, The woman showed Officer C the injury she had made to her hand with the pin and said that staff were not listening to her. At 4.20pm, the woman told her case worker that she had taken six tablets of promethazine hydrochloride because she was fed up with prison. The woman's case worker was concerned that she had been allowed to keep these tablets in her possession when she had been identified as at risk of suicide and self-harm. Healthcare staff checked the woman and concluded that the amount she had taken was not likely to harm her. However, they monitored the woman for drowsiness and other potential side effects.
50. At 4.50pm, SO G held a ninth ACCT case review with the woman. The woman said that she felt low and had had enough. SO G assessed her risk of suicide and self-harm as low but increased the frequency of observations to once an hour until a multidisciplinary review could be held. In addition to the usual ACCT checks, nurses monitored the woman at 7.30pm and 11.00pm to check there had been no consequences from the overdose.
51. On 3 July, SO H chaired a tenth ACCT case review with Officer D and the woman. The woman explained that she had taken the overdose the previous day because her boyfriend had not replied to her letters. The staff assessed her risk of suicide and self-harm as low. They maintained the required frequency of observations at one an hour, with the day staff expected to record three summaries each day, instead of recording separate hourly checks. The SO noted on the caremap that there was no need to hold an ACCT case review every time the woman self-harmed unless her methods became more serious or there were three or more incidents of self-harm within 24 hours. This was in line with Prison Service Instruction 64/2011, which advises staff to hold a case review if there is an increase in either frequency or lethality.
52. The same day, staff at a multidisciplinary complex cases meeting discussed the woman. (This is a weekly meeting with representatives from different teams in Holloway to discuss any women who are causing concern) the meeting decided that after the events of the previous day, the woman should not be allowed to keep any medication in her possession. Later, the member of staff from the programme's team told the woman that she was ineligible to attend the day centre, because they were not accepting women from the residential units. The woman asked what support was available from her local community mental health team when she was released, and he emailed two members of the prison mental health team about this and asked them to check.

53. On 4 July, the woman's case worker reviewed the woman. On the evening of 6 July, the woman spoke to a Listener. On 7 July, SO A held an IEP review and changed the woman's IEP status from basic back to entry level (rather than standard).
54. The woman was sharing a cell with prisoner A. On 7 July, they had an argument. They were moved to different cells on B4 unit and both warned about their behaviour. The woman told other prisoners that prisoner A had threatened her, which upset prisoner A. On 8 July, wing managers told the woman that she would be moving to A4 unit and she loudly accused prisoner A of having her moved. Staff advised prisoner A to stay away from her. Later that day, in the education department, prisoner B, asked the woman to come to the toilets. An education manager noticed this happening and found prisoner B, prisoner C and prisoner D waiting in a toilet cubicle. The woman was not harmed and the education manager completed a violence report form about the incident.
55. SO A placed the other four women on the basic regime while the incident was investigated. Prisoner A became very upset and pushed past SO A to try and assault the woman. Staff had to use force to lock her in her cell.
56. Later on 8 July, The woman moved to a dormitory, on A4 unit. At 1.40pm, SO A held an eleventh ACCT case review with no other staff present. SO A noted that the woman had been talking out of turn about prisoner A and had consequently put her own safety at risk. The woman said she felt safer on A4 unit. SO A assessed her risk of suicide and self-harm as low and maintained hourly observations. She placed the woman on the basic regime for her part in aggravating the recent incidents, exaggerating the seriousness and spreading rumours among other women on the unit.
57. SO A and the head of Safer Custody investigated the incident in the education department. The four other women were all placed on the basic regime and restricted to their unit for 14 days, by which time the woman was due to have been released. The woman remained on the basic regime for 14 days.
58. On 11 July, the head of Safer Custody, SO G, Nurse B and a substance misuse support worker held a twelfth ACCT case review. The head of Safer Custody informed the woman that she was being placed on the basic regime for 14 days as a result of the investigation. However, she was allowed to remain in her current dormitory for support and could continue to attend education and have exercise periods. The woman was concerned about her safety when she was coming back from exercise periods and the review panel agreed that a member of staff should escort her back if she requested this.
59. SO G asked the woman to think about how she dealt with other prisoners to minimise the risk of further confrontations. The woman said that she self-harmed when she had arguments or had problems at home. They discussed other ways of coping and the woman agreed to talk to staff if she felt like harming herself.
60. The woman was concerned that her antidepressants were not working. She said that she was getting enough support in prison but wanted mental health



support after her release, which she was looking forward to. She said that she did not have any current thoughts of self-harm. The staff assessed her risk of suicide and self-harm as low. They agreed that hourly observations should continue (recorded as summaries in the morning, afternoon, evening and at night) with two conversations each day with the woman. SO G added three more issues to the caremap:

- The need for the woman to keep herself busy in her cell - the substance misuse team would give her in-cell work to do;
- Mental health issues – SO G sent referrals to the mental health team and the Women in Prison team for post-release support;
- Support from SO G.

61. On 12 July, the woman was accused of entering another prisoner's cell and throwing her letters on the floor. Officers attempted mediation, but this did not go well and the two women agreed to avoid each other. Officer E locked the woman in her cell because of her behaviour. Later that morning, the woman told the officer that she had had a seizure. A nurse checked the woman but found no symptoms indicating that she had had a seizure.
62. On 13 July, the woman told Officer F that another prisoner had told her that the four other women intended to assault her when they came off the basic regime. The officer completed a violence report form. On 13 and 14 July, Officer G noted in the woman's record that she was concerned that the woman was pushing the boundaries of acceptable behaviour by disobeying officers and ignoring rules.
63. On 15 July, following a referral from St Mungo's, the Southend homeless panel discussed the woman and identified three hostels that might accommodate her when she was released. The woman had not yet made up her mind about whether to accept a hostel place, but staff arranged a telephone interview with one of the hostels for the afternoon of 21 July.
64. The same day, Officer G noted that the woman's behaviour was very poor. She was shouting and continuing to ignore rules. The SO spoke to the woman about the violence reduction form Officer F had submitted and reassured her that none of the other women would come off the basic regime until after she had been released. Later, the member of staff from programme's team went to speak to the woman about mental health support when she was released. However, he realised that he had not received a reply to his earlier email about possible support from the community mental health team. He emailed the prison mental health team again.
65. At 5.50pm on 15 July, Officer H placed the woman on a disciplinary charge for threatening to punch her. The woman made small cuts to her arm afterwards but staff decided not to hold an ACCT case review. The woman agreed that this was not necessary and told SO G that she had harmed herself because she had been annoyed about being placed on a charge and because her boyfriend was 'being a pain'.
66. On 16 July, the prison mental health team replied to the member of staff from the programme's team and said that they would discuss the woman at the weekly referrals meeting later that day as SO G had made a referral. At the

meeting, the mental health team again declined to accept the woman onto their caseload because she did not meet their criteria and they could not do any useful work in the eight days before her release. Because the woman was not under the care of the mental health team in prison, they were unable to refer her to the community mental health team in Southend as he had hoped. The meeting proposed that he should arrange a resettlement review and that he should send a copy to the woman's local GP.

67. Also on 16 July, the woman told her St Mungo's post-release support worker that she was currently on the basic regime because she had been caught in the toilets with Officer I. The St Mungo's post-release support worker told Officer I what the woman had said and, on his advice, submitted an intelligence report to the security department. She did not believe the allegations but was concerned that the woman was developing an unhealthy obsession with the officer.
68. Later on 16 July, the woman encountered prisoner E in a pottery class. Prisoner E was the aunt of prisoner B, one of the prisoners who had been involved in the incident with prisoner A. Other prisoners pointed out the woman to prisoner E. Prisoner E told the investigator that she had challenged the woman about the impact her behaviour had had on her niece. The investigator asked to speak to the pottery class teacher to see whether he or she recalled the incident but Holloway was unable to identify who this member of staff was. There was no entry in the woman's ACCT document about it.
69. On 17 July, the woman's disciplinary hearing about threatening Officer H was adjourned as the officer was not available that day. The member of staff from the programme's team saw the woman and explained what had happened about her mental health referral. He advised her to visit her GP, when she was released, to see if she could get support from the community mental health team. He contacted the Women in Prison team to check that they would support the woman when she was released. The same day, the woman told the wing staff that Officer I had promised to come and speak to her if she was feeling low. They contacted Officer I, who denied this. The woman said she was concerned that her mother might take an overdose. Wing staff telephoned her grandmother to pass on the woman's concerns about her mother and let the woman know that they had done this. Later that evening, the woman spoke to a Listener.
70. At about 8.00am on 18 July, the woman phoned her mother and then a friend. She talked about her plans for the day she was released, when she intended to travel to Southend and have a meal with relatives. The woman used the telephone frequently and used up all of her remaining credit that day. She made no further phone calls from the prison.
71. The member of staff from the programme's team spoke to a member of staff from the Women in Prison team on 18 July about ongoing support for the woman. She arranged for one of her team to see the woman in the resettlement department on the afternoon of 21 July to help make arrangements for her release and to meet the woman at the gate when she was released on 24 July, for ongoing support.

72. At 10.30am on 18 July, SO G chaired a thirteenth ACCT case review with Nurse C and the woman's case worker. The SO challenged the woman about an earlier outburst on the unit. She apologised and said that she tended to act without thinking, for example by harming herself impulsively. She said she was excited about her forthcoming release and had no thoughts of self-harm. The staff assessed her risk of suicide and self-harm as low and maintained hourly observations and with contact recorded as previously. The SO decided that the woman should remain on the basic regime for another seven days because her behaviour was still not acceptable.
73. That afternoon, the woman and prisoner E moved to a double cell in C4 unit, C4-22, so their dormitory on A4 unit could be used for women who were not on the basic regime. In the dormitory, they had had a television despite being on the basic regime, but they were not allowed one in the cell in C4 unit as they were both on basic.
74. A custodial manager, B, and Officer J held a fourteenth ACCT case review immediately after the woman moved to C4 unit on 18 July. The woman said that she was pleased to be on C4 unit where she recognised friends. She was also glad to share with prisoner J, because they got on well. The custodial manager told the investigator that the woman was happy, engaged, positive and relaxed and looking forward to seeing her family. She did not disclose any thoughts about suicide or self-harm. He reminded her that she could seek support from staff or Listeners. He kept the ACCT document open as a precaution because he knew that the woman tended to harm herself if she became upset and she only had a few days until release.
75. The staff told the woman that someone from the Women in Prison team would meet her at the gate when she was released on 24 July and would accompany her back to Southend and attend any appointments with her if necessary. They continued to assess her risk of suicide and self-harm as low and did not change the level of observations. The custodial manager told the investigator that it was a straightforward review and he had no serious concerns about the woman. He arranged the next case review for 23 July, the day before her planned release.
76. At about 8.30pm on 18 July, the woman said that she had hit her head on a locker when she had fallen out of bed while having a seizure. The custodial manager and Nurse D went to see her. The nurse checked the woman but could not see any injuries. She advised the woman to drink more fluids and sleep with her mattress on the floor.
77. SO G told the investigator that after the woman moved to C4 unit, he and Officer K interviewed her about the allegation that she had been having a relationship with Officer I. The woman denied the allegation and SO G subsequently submitted an intelligence report.
78. On 19 July, the woman's disciplinary hearing for allegedly threatening Officer H was adjourned again because she felt unfit to proceed after suffering the seizure the night before. At about 4.00pm, wing staff found the woman in a state of collapse. Nurse D checked her and she recovered with no obvious injuries. The woman said that she had become hot and stressed. Nurse D advised her to drink plenty of fluids as the weather was extremely hot.

Afterwards, Nurse D sent an email to find out if a definite date for the woman's neurology outpatient appointment had been received. (There is no indication in the woman's clinical record that a date for an appointment had been received by the time of her death.)

79. That evening, the woman asked to speak to a particular Listener. Officer K told her that she could only see the Listener who was scheduled to be on duty at the time. The woman then decided she did not want to see anyone.
80. On Sunday 20 July, The woman attended a service in the chapel where Officer I challenged her for being noisy and disruptive. At about 5.20pm, the woman alleged to wing staff that prisoner G had threatened to punch her in the face. Staff did not witness this and prisoner G denied threatening the woman, although she said that she had been upset by a remark the woman had made about her deceased father. The two women were each warned to stay away from each other. Prisoner G told SO G that the woman had claimed to have had a relationship with an officer during a previous sentence and was currently claiming to be having a relationship with Officer I. At 6.35pm, the woman spoke to a Listener. ACCT entries during the night indicate that the woman slept soundly.

### **Monday 21 July**

81. At 10.40am on 21 July, the woman attended a pre-release interview with Officer L in the resettlement department. (The woman had been scheduled to see Officer I but he had asked Officer L to take his place because of the rumours the woman was spreading.) Officer L organised a travel warrant to Southend for 24 July. She told the investigator that the woman was cheerful and looking forward to going home and seeing her mother. She did not see any signs that the woman was anxious or depressed. While the woman was in the resettlement department, the resettlement manager told her that she would organise her pre-arranged telephone interview with a hostel that afternoon.
82. Officer I and a colleague, Officer M, both saw the woman when she was in the resettlement department that morning. They said that she was laughing, friendly, chatty and bubbly. They thought that she seemed excited to be going home. Prisoner G was also in the resettlement department that morning. She told Officer I that the woman had claimed that he had asked her to 'wiggle her bum' at him when she was outside during an exercise period. Officer I immediately submitted an intelligence report that was passed to SO G.
83. SO G telephoned Officer I after he received his intelligence report and said that he planned to speak to the woman about her allegations about him that afternoon with a female officer present. He also planned to hold an ACCT case review with the woman afterwards. Officer I asked the resettlement manager to see the woman on C4 unit instead of the resettlement department. SO G went to C4 unit and asked the staff to keep the woman on the unit after lunch.
84. On 21 July, staff wrote summaries of their contact with the woman in the ACCT record at half past midnight, 6.00am, 6.55am, 7.05am, 8.50am and

11.00am. The latter two entries recorded the woman's visit to the resettlement unit. Officer N made another entry after the 11.00am entry but this was not timed. She wrote that the woman was in good spirits, said she was fine and that the agreed level was being maintained. Officer N told the investigator that she made this entry at about midday, before she went to lunch.

85. Officer N said that she saw the woman when she came back from the resettlement unit. She told the woman that she would be staying on the unit after lunch and someone from the resettlement unit would be coming to see her. The woman was annoyed and wanted to know why, but Officer N did not tell her that SO G wanted to talk to her about the allegations she had made about Officer I. The woman ate lunch with prisoner F in their cell and they were locked up over the lunch period. As well as having an appointment to see the resettlement manager about her accommodation that afternoon, the woman had appointments arranged with a GP to discuss a mole on her scalp and with an advisor from the Women in Prison team about arrangements for her release.
86. At 1.45pm, Officer K and Officer N unlocked the women who were attending activities. They unlocked cell C4-22 and prisoner F went to the activities centre. They told the woman that she would be locked in her cell again until she had her resettlement interview and she became tearful. Officer K believed that she had told the woman that an SO wanted to speak to her but she did not think she had said it was SO G. The woman said that she did not want to be locked in the cell on her own because she had already spent a lot of time in the cell on the basic regime. She asked to be let off the unit to attend her appointments. The officers decided not to lock the woman in her cell immediately, and asked her to wait by the cell while they finished moving the other women off the unit.
87. On the way to activities, prisoner F showed other prisoners a note which the woman had given her and asked her to pass on to Officer I. The woman had written:
- ‘To Officer I. It’s me could you come and see me in C4 please need to talk to you and I can’t talk to my staff. Many thanks. The woman.’
88. Someone threw the note out of a window. It landed by Officer O, who read it and telephoned Officer I. Officer I collected the note from her and showed it to SO G.
89. Once the other women had gone to activities, Officer N and Officer K went back to speak to the woman. She became angry and Officer K told her to calm down or she was likely to be charged with a disciplinary offence. Officer N telephoned SO G to check if the woman could leave the unit after he had spoken to her. SO G said that the resettlement manager was also coming to the unit to see the woman, so this would probably not be possible.
90. The woman calmed down but was still tearful. She believed that staff did not want her to go to her appointments because of what she had been saying about Officer I. She then brightened and asked if she could help paint the landing. Officer K said that this was not possible and gave the woman one of

her own magazines to read. She said that the woman seemed happier but was still a little tearful when she locked her in her cell at about 2.10pm. Officer N left the unit to work in the visits area that afternoon.

91. Officer K told the investigator that she checked the woman again at about 2.40pm. At the time she was lying on her bed reading the magazine and did not speak or look up. Officer K did not make any entries in the ACCT document about any of the events after lunch because she planned to write a summary at the end of the afternoon.
92. At about 3.30pm, officers escorted prisoner F and prisoner H (who lived in the dormitory opposite) back to C4 unit. Officer K told them to wait outside their locked cells. The observation panel on prisoner F's and the woman's cell door was open, but the toilet door inside the cell was also open, which obscured the view into the cell. Prisoner F reached through the observation panel and pushed the toilet door closed. The view into the cell was now unobstructed. She said that she then saw the woman hanging. Prisoner H told the investigator a slightly different version of events. She said that prisoner F, did not look properly into the cell, but went to find an officer to unlock it. Prisoner H said that it was she who had looked inside and seen the woman hanging from the top bunk bed. The woman had tied one end of a piece of green bed sheet around her neck and the other end around the top part of the bed frame. She was kneeling on the floor facing the bunk bed with her feet behind her. Prisoner H said that she had shouted to prisoner F, who had turned around and also looked through the observation panel.
93. Prisoners H and F both shouted to staff for help. Officer K was only about ten feet away. When she got to the cell and looked through the observation panel she asked the prisoners to get help from other staff. She did not use her radio as she knew staff were very close by and she wanted to go into the cell immediately and help the woman. Officer K unlocked the cell, went in and cut through the sheet around the woman's neck with a special tool, which all officers are required to carry. She lowered the woman to the floor by herself and noted that she was not breathing.
94. A custodial manager, A (who was the orderly officer, in charge of the routine operation of the prison that day) and SO G were in the office discussing the woman and looking at her ACCT document at the time. They said that prisoner F and prisoner H ran to the office, shouting, 'She's hanging!', and one of them pressed the general alarm on the wall. Custodial manager A left the office, also pressed the general alarm and ran to the cell. SO G followed her after locking the office. At 3.34pm, staff throughout the prison heard an alarm across the radio network and a message stating, 'General alarm on C4.'
95. When custodial manager A arrived at the cell, Officer K was lowering the woman to the ground. She radioed for urgent medical assistance and then announced a code blue emergency (the correct code to indicate a medical emergency when a prisoner is not breathing or unconscious). Officer K shouted to her to use code black (the code previously used) so the custodial manager also radioed a code black emergency. At 3.35pm, the control room staff requested an ambulance.

96. Custodial manager A began chest compressions to try to resuscitate the woman. Another custodial manager, B, SO G and SO I then also arrived. Custodial manager B and Officer K took turns to give rescue breaths.
97. The first healthcare staff on the scene, Nurse E and Nurse F, arrived about three minutes later. Nurse E took over breaths from custodial manager B while Nurse E collected the emergency response bag containing an oxygen cylinder from neighbouring B4 unit. Officer P brought a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). Officer Q and Officer B brought a second, larger oxygen cylinder from a nearby clinic. Nurse G, the primary care manager, arrived and custodial manager continued to perform chest compressions.
98. Staff put up a screen to provide some privacy around the cell. Nurse C attached the defibrillator but it did not detect a shockable heart rhythm and the staff therefore continued to attempt cardiopulmonary resuscitation. Two doctors and other nurses arrived.
99. At 3.39pm, a first response vehicle arrived at the prison gate. A rapid response vehicle and an ambulance followed shortly after. The three different emergency vehicles were all escorted to C block. At 3.45pm, a first response paramedic arrived on the unit and used their defibrillator to check the woman. Again there was no shockable rhythm. Ambulance paramedics arrived on the landing at 3.48pm and the rapid response crew, including two rapid response doctors, arrived on the unit at 3.52pm. They attached an 'Autopulse' to the woman (this is a recently-introduced machine which squeezes the patient's chest to deliver more efficient compressions). They gave the woman adrenaline.
100. While staff continued to resuscitate the woman, the rapid response doctors began to think that the resuscitation effort might be futile. However, the paramedics then found a weak pulse and they decided to take the woman to hospital. Prison staff helped the paramedics to move the woman to the ambulance. At 4.33pm, the woman left in the ambulance escorted by Officer L and Officer R, to go to the Royal London Hospital. The woman was not restrained. (The Governor rescinded an initial risk assessment indicating the woman should be restrained when she saw her condition. However, it is concerning that anyone should ever have considered that restraints were appropriate in the circumstances.)
101. Officers placed prisoner F in a nearby dormitory and locked all the other women prisoners in their cells and patrolled the level 4 units to check the women during and after the emergency response. They reviewed prisoners subject to ACCT procedures. When the rest of the women returned from activities, staff briefed them as a group about what had happened. They were offered support, including from the chaplaincy, Listeners and Samaritans.
102. Officer P acted as the prison's family liaison officer. She left an urgent message for the woman's mother. When there was no immediate reply and hospital staff advised that the woman's prognosis was poor, prison staff asked the local police to visit her mother. The woman's mother then contacted the prison for more information and she and the woman's father went to the

hospital. Staff involved in the emergency response attended a debrief meeting at 5.00pm.

103. On 22 July, Officer P, head of Safer Custody and a prison chaplain visited the hospital. With the consent of the woman's parents, doctors switched off her life support machine and she died just after 5.00pm.
104. On 25 July, the family liaison officer visited the woman's mother to offer condolences and support. On 29 July, the woman's mother attended a memorial service for the woman at Holloway. She visited her daughter's cell and met prisoner F. Managers held a further debrief for staff on Monday 11 August. The prison paid for the woman's funeral, which was held on 15 August. A prison chaplain officiated at the woman's family's request. A post-mortem examination found that the cause of death was the brain being starved of oxygen as a result of suspension by ligature.
105. Among the belongings found in the woman's cell were some handwritten notes and letters, one of which was a poem entitled 'My first suicide'. This was a poem she had copied out, which was originally written by another prisoner at a different prison and published in the prisoner newspaper 'Inside Time'.



## ISSUES

### Management of risk of suicide and self-harm

106. The woman was identified as being at risk of suicide and self-harm when she first arrived at Holloway. Staff opened an ACCT document and managed her under ACCT procedures for the rest of her time there. Despite this, the woman was on the basic level of the Incentives and Earned Privileges (IEP) scheme for the majority of her sentence, which meant that she had more restricted time out cell, reduced funds to spend on items such as tobacco and telephone calls and more restricted visits. She was not allowed a television. On the afternoon the woman hanged herself, she told staff that she had already spent too long locked in her cell on the basic regime.
107. While prison staff have to manage challenging behaviour, this can also mask increased vulnerability. We have identified in previous Learning Lessons Bulletins that prisoners who are difficult to manage, particularly of the woman's age, can be at a higher risk of suicide when faced with ongoing loss of privileges. There is therefore a need to ensure that decisions to place prisoners on the basic regime take account of their vulnerability and are not taken in isolation. While we are concerned that the woman was subject to the basic regime for much of her time at Holloway, decisions about the woman's IEP status were often taken in the context of ACCT reviews so staff were aware of her vulnerability. Staff also discussed her management at a multidisciplinary complex cases meeting.
108. However, Holloway, did not always operate the ACCT procedures in line with national guidance and we cannot be satisfied that the extent of her vulnerability was always fully identified. We found a lack of continuity of ACCT case manager, partly due to the woman moving between different residential units. This was a problem that HM Inspectorate of Prisons identified during their last inspection. SO D was named as the case manager on the ACCT caremap, even though the woman had left the detoxification unit where SO D worked a month earlier. While some ACCT case reviews were multidisciplinary, several involved only the person chairing the review, particularly after the woman moved from the detoxification unit. ACCT reviews should involve more than one member of staff and, again, this was something that HMIP had criticised.
109. The quality of ACCT risk assessments was often inadequate. Staff can assess a prisoner as being at low, raised or high risk and the level of support they receive should reflect this level of risk. There was little evidence that ACCT reviews reflected the changes in the woman's mood. She was assessed as low risk at each of 14 successive reviews, even though the woman had harmed herself, been both a perpetrator and victim of bullying (a recorded trigger for further self-harm), and had several disciplinary problems resulting in being placed on the basic level of the IEP scheme and her spending more time locked in her cell.
110. Staff told the investigator that they always considered the woman to be a low risk of suicide. However, ACCT risk assessment explicitly relates to the risk of suicide *and* self-harm. Guidance in the ACCT document itself states that current self-harming behaviour should prompt a raised risk assessment. Even

after very recent incidents of self-harm, staff continued to assess the woman's level of risk as low.

111. Most of the issues identified in the ACCT caremap, such as a housing referral, a referral to the doctor for epilepsy and a mental health referral, were realistic and achievable and were completed by case managers. However, staff issued the woman with razors in early June when the ACCT caremap specifically instructed them not to. The woman told staff that she had been raped shortly before arriving in prison. At her request, this was not reported to the police but this issue was not recorded in the caremap. Although SO D planned to refer her to the Women in Prison team to help with the possible consequences of the alleged rape, this was outside the ACCT process and there was no follow up. Because the issue was not added to the caremap, case managers never returned to it to check that the woman received ongoing support.
112. It is common practice at Holloway for officers not to record each ACCT observation individually but to make several summaries each day of their contact with the prisoner. An instruction to this effect was outlined on the front cover of the woman's ACCT document. The idea of summarising observations in a meaningful way has some merit as there is a risk that frequent observations can lead to repetitive and routine entries in ACCT documents. A summary enables staff to reflect on a morning or afternoon and make a holistic entry about the prisoner's mood. Prison Service Instruction (PSI) 64/2011, which sets out policy on safer custody, states that a good quality, meaningful entry can communicate more than pages of meaningless comments. Nevertheless, we do not consider that summaries should replace a record of each observation as they occur, but can be helpful additions. There is a need for staff to provide some assurance that they monitor prisoners at risk of suicide and self-harm in line with the agreed frequency for observations.
113. On 21 July, the last recorded timed entry in the woman's ACCT document was at 11.00am. (There was one further entry that was not timed, which Officer N says she made at about midday.) Staff were required to observe the woman at least once each hour, yet there is no timed record of any checks for three and a half hours before staff found the woman hanged. In line with the accepted practice at Holloway, Officer P had planned to make a summary entry at the end of the afternoon. This means she did not use the ACCT ongoing record to make entries at the time about:
  - SO G's planned visit and the reason the woman was in her cell
  - The woman becoming tearful when she was locked up
  - giving the woman a magazine to help occupy her
  - making a subsequent satisfactory check on her
114. We have no reason to doubt the officer's recollection of these events but it is unsatisfactory to have to rely on an officer's account after a death, rather than actual observations recorded at the time.
115. PSI 64/2011 states that observations and conversations should be recorded immediately or as soon as is practicable. We consider that, in line with this, all observations should be recorded as they occur. It is particularly important

that information about a change in risk or mood is recorded immediately to assist other colleagues. For example, had Officer P been moved to different duties without warning, as can happen during the prison day, none of her colleagues would have been able to refer to the ACCT document for an up-to-date account of the woman's mood on the day she was found hanging. We also note that the woman had contact with staff other than wing officers such as the Women in Prison Team and the member of staff from the programmes team. None of their contact with the woman is recorded in the ACCT document, and there are only infrequent entries from other professionals (such as trainers) who came into contact with the woman.

116. We make the following recommendation:

**The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:**

- **Holding multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care and assess the level of risk taking into account all risk factors;**
- **Continuity of case management at ACCT case reviews;**
- **Reviewing caremaps at each review and adding relevant new issues as appropriate;**
- **Setting appropriate levels of observations which are adjusted as the perceived risk changes;**
- **Recording ACCT observations immediately or as soon as possible after they are made; and**
- **Staff from all disciplines and agencies involved with a prison recording all meaningful contacts in the ACCT record.**

## **Bullying**

117. The woman was sometimes seen as a perpetrator and also a victim of antisocial behaviour. The most significant incident took place on 8 July, when four other women tried to intimidate her. Staff intervened before anything could happen and, following a swift investigation, took sensible steps to keep the woman safe. The other women were placed on the basic regime and were not allowed off their units for 14 days, by which time the woman would have been released. The woman did not report any significant distress afterwards at ACCT case reviews. We think that safer custody staff handled the incident on 8 July and its aftermath well.

## **Clinical care**

118. The woman lived in the prison's dedicated detoxification unit for the first few weeks of her sentence. This allowed healthcare staff to ensure that she successfully detoxified from alcohol after two courses of chlordiazepoxide. The clinical reviewer, had no concerns about the management of her withdrawal.

119. Nurses on the unit did not identify any significant underlying mental health concerns. Staff referred the woman to the mental health team, once in reception and once near to her release. The mental health team discussed her at weekly case meetings after both referrals but decided that she did not

meet the criteria. Although she possibly had a personality disorder, her sentence was not long enough for staff to address this. The woman was also actively self-harming, which disqualified her from entering the specially-designed personality disorder programme.

120. The woman received support from a substance misuse worker and through the ACCT suicide and self-harm prevention procedures. The clinical reviewer had no concerns about the way the woman's mental health referrals were handled. He found that she was offered clinical care equivalent to that she could have expected in the community.
121. However, we agree with the clinical reviewer that healthcare staff should not have given the woman sleeping tablets to keep in her possession as happened in early July. This was inappropriate because she was subject to ACCT procedures, and also because an in-possession risk assessment had not been completed. (Section 4 of Holloway's In Possession Medication Policy requires a prisoner to be risk assessed before being issued with medication.) The woman later harmed herself by swallowing six sleeping pills. Although the attempted overdose was acknowledged at an ACCT case review, no reference was made to reassessing the risk of allowing medication to be kept in possession or the outcome. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prisoners are allowed to keep medication in possession only when endorsed by a full risk assessment. Risk assessments for prisoners identified as at risk of suicide and self-harm should be reviewed when ACCTs are opened.**

### **Alleged relationship with Officer I**

122. The woman made a number of remarks to prisoners and members of staff suggesting that she was having an inappropriate relationship with Officer I. The officer reported the woman's comments to prison managers as soon as he heard about them. An internal investigation was carried out and found no evidence to support these allegations.
123. Following our interviews with staff and prisoners, we have drawn the same conclusion. The woman appears to have suggested a connection with Officer I that did not exist. Staff described the woman positively during our interviews, but often said that she was quite immature for her age. Other prisoners said that they had not believed the woman's claims and thought that she was making up the idea of a relationship because she was infatuated with Officer I. It is also worth noting that the woman had previously falsely suggested that a different officer was attracted to her.

### **Emergency response**

124. The clinical reviewer is satisfied that, when staff found the woman hanging, they performed resuscitation appropriately.
125. PSI 03/2013 outlines the correct way for staff at the scene to alert control room staff and colleagues to a medical emergency. When they discovered the woman hanging, staff should have immediately radioed a code blue

emergency. Perhaps understandably, Officer K's immediate reaction was to go into the cell and cut the ligature from the woman's neck. This was prompt and effective action, but asking other prisoners to alert staff appears to have led to some initial confusion about the nature of the emergency and a general alarm was called first. (A general alarm can be confusing for other colleagues on the radio network, because it can signify any kind of serious incident, such as a disturbance or a fight.) Custodial manager A requested urgent medical assistance when she reached the cell, then announced a code blue shortly afterwards and finally a code black (a code that is no longer used at Holloway).

126. Holloway introduced their local policy based on PSI 03/2013 on 9 December 2013. It requires staff to call either a code blue or a code red emergency, which prompts control room staff to call an ambulance immediately. Custodial manager A said that she and her colleagues had been made aware of the local policy. However, during this emergency, they did not follow it. We are satisfied that there was no delay in the emergency response on this occasion and that the control room staff immediately called an ambulance, but a failure to communicate clearly using the right code might make a difference in a future emergency. We make the following recommendation:

**The Governor should ensure that all prison staff are reminded of and understand PSI 03/2013 and their responsibilities during medical emergencies.**

## RECOMMENDATIONS

1. The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - Holding multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care and assess the level of risk taking into account all risk factors;
  - Continuity of case management at ACCT case reviews;
  - Reviewing caremaps at each review and adding relevant new issues as appropriate;
  - Setting appropriate levels of observations which are adjusted as the perceived risk changes;
  - Recording ACCT observations immediately or as soon as possible after they are made; and
  - Staff from all disciplines and agencies involved with a prison recording all meaningful contacts in the ACCT record.
2. The Governor and Head of Healthcare should ensure that prisoners are allowed to keep medication in possession only when endorsed by a full risk assessment. Risk assessments for prisoners identified as at risk of suicide and self-harm should be reviewed when ACCTs are opened.
3. The Governor should ensure that all prison staff are reminded of and understand PSI 03/2013 and their responsibilities during medical emergencies.

**ACTION PLAN: The death of a woman at HMP Holloway on 22/07/2014**

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <ul style="list-style-type: none"> <li>• A. Holding multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care and assess the level of risk taking into account all risk factors;</li> <li>• B. Continuity of case management at ACCT case reviews;</li> <li>• C. Reviewing caremaps at each review and adding relevant new issues as appropriate;</li> <li>• D. Setting appropriate levels of observations which are adjusted as the perceived risk changes;</li> <li>• E. Recording ACCT observations</li> </ul>	Accepted	<p>Management action will be taken requiring Duty Governors to complete a weekly review of attendance at ACCT case reviews to consider whether they were multidisciplinary.</p> <p>Local ACCT training will be provided for all ACCT Case Managers, with specific reference to the requirement for multi-disciplinary attendance and the team giving consideration of the level of risk based on all known risk factors at ACCT case reviews. In addition, a Governor's notice to staff will be sent to all ACCT Case Managers requiring them to ensure all their ACCT reviews are multi-disciplinary and attended by other staff involved in the prisoner's care. If other staff are unavailable at the time of the review, the review should be recorded as an interim review and a multi-disciplinary review must be carried out within the next 24 hours.</p> <p>The local ACCT Case Manager training will remind staff of the need for continuity of case manager wherever possible, and schedule ACCT case reviews for times when they know they will be on duty. ACCT case managers will be required to</p>	<p>Head of Residence and Safety 31<sup>st</sup> August 2015</p>	

	<p>immediately or as soon as possible after they are made; and</p> <ul style="list-style-type: none"> <li>• F. Staff from all disciplines and agencies involved with a prison recording all meaningful contacts in the ACCT record.</li> </ul>		<p>provide end-to-end case management within the Level (equivalent to a wing in other prisons) where they work, unless the prisoner is relocated to a different level.</p> <p>The local ACCT case manager training will emphasise the need to review the Caremap at each ACCT case review. In addition, this training will remind staff of the need to consider known risk factors, and review and amend the level of observations as the level of perceived risk changes.</p> <p>New guidance will be issued which requires staff to record in the ACCT any signs of distress and what measures have been taken to alleviate it. Staff will also be reminded of the national policy requirement to record ACCT observations "immediately or as soon as practicable". Entries will always be made before a woman leaves the unit or activity area as a recorded handover of any risk factors.</p> <p>The local ACCT case manager training and any local ACCT refresher training will include specific reference to the need to document distress and the measures taken to alleviate it.</p> <p>A Notice to Staff will be issued to remind staff involved in the care of a prisoner subject to an ACCT that they must record all meaningful contacts in the ACCT ongoing record.</p>	<p>Head of Residence and Safety 31<sup>st</sup> March 2015</p>	
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2	<p>The Governor and Head of Healthcare should ensure that prisoners are allowed to keep medication in possession only when endorsed by a full risk assessment. Risk assessments for prisoners identified as at risk of suicide and self-harm should be reviewed when ACCTs are opened.</p>	Accepted	<p>A Clinical report will be run on SystmOne to identify those women who do not have current in-possession medication risk assessments and this will be cross referenced with prescription charts. It is accepted that medication should only be prescribed as in-possession following the completion of an in-possession risk assessment, as required by local policy.</p> <p>The Head of Healthcare will notify primary care staff of this requirement and ensure it is included in the induction programme for new staff.</p> <p>Any member of staff opening an ACCT is required by local policy to inform Healthcare of its existence. In addition, the safer custody staff will also provide a weekly list of open ACCTs for primary care staff to refer to, and ensure that the in-possession risk assessment is reviewed where there is an open ACCT and consideration is given to whether in-possession medication is appropriate.</p>	<p>Head of Healthcare 31<sup>st</sup> August 2015</p>	
3	<p>The Governor should ensure that all prison staff are reminded of and understand PSI 03/2013 and their responsibilities during medical emergencies.</p>	Accepted	<p>Staff will be reminded of this requirement at a full staff meeting and the local Notice to Staff will be re-issued at quarterly intervals.</p>	<p>Head of Residence and Safety 30<sup>th</sup> April 2015</p>	