

**Investigation into the circumstances surrounding
the death of a woman
at HMP & YOI Downview in March 2011**

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

July 2013

This is the report into the circumstances surrounding the death of a woman at HMP Downview in March 2011. She was 24 years old and was found hanging in her cell. I offer my condolences to her family and friends.

A clinical review of the treatment which the woman received in prison was undertaken by a clinical reviewer, who was appointed by the local PCT. Downview co-operated fully with the investigation. I apologise for the delay in issuing this report.

The woman was sentenced in August 2010 and transferred to Downview a week later. She had been dependent on alcohol and heroin and had a history of mental health problems. During the autumn she completed an opiate withdrawal programme. However, in early 2011, she relapsed and was found to be using illicitly obtained Subutex (a heroin substitute). She was seen regularly by a psychiatric nurse from the mental health in-reach team throughout her time at Downview.

On 14 March, a former prisoner, with whom the woman had been having a relationship, was found murdered. Because of her distress, the prison began suicide and self-harm monitoring and officers were required to check on her twice an hour when she was locked in her cell. At a review on 24 March, it was noted that she was beginning to feel better and observations were only needed at night time. On 29 March, a senior officer responsible for safer custody questioned the decision about the level of risk during the day. It was agreed that this would be revisited at a review the following day. However, before this review took place, she was found dead.

The woman had given no indication to prison staff that she intended to take her own life, but one of her friends had asked an officer to check on her because she was concerned about her state of mind. The officer spoke to her, who told him that there was no need for further checks. Nevertheless, he arranged for another officer to check her again. Some time after this she appears to have hanged herself with a length of torn bed sheet.

The clinical review concluded that the healthcare the woman received in custody was comparable to that which she could have expected in the community. However, the investigation found a number of areas that require improvement at Downview, including the handling of bullying, the management of the suicide prevention and self-harm monitoring process and the response to emergencies. It is not possible to say with any certainty that the outcome would have been different if these weaknesses had been addressed.

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

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Prisons and Probation Ombudsman

July 2013

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SUMMARY

1. The woman had a long history of alcohol and heroin misuse, as well as mental health problems. She was arrested for an offence of armed robbery in April 2010, remanded into custody and taken to HMP Bronzefield. While she was held at Bronzefield she was prescribed methadone, a heroin substitute.
2. The woman received a 32 month prison sentence on 12 August, 2010. A week later, on 19 August, she transferred to HMP Downview. After she arrived, she was assessed by a substance misuse worker. She began a managed withdrawal from methadone. Her detoxification programme continued during the autumn and, after a change to another heroin substitute, Subutex, she completed her withdrawal shortly before Christmas. However, by February 2011 she had relapsed and was illicitly using Subutex on the wing.
3. After she moved to Downview, the woman was accepted onto the mental health in-reach team's caseload because of her mental health problems. She met regularly with a psychiatric nurse from the in-reach team, and was prescribed an antidepressant. In early 2011, the healthcare staff decided to try a different antidepressant and an antipsychotic drug to stabilise her mood. She was also given medication to manage her epilepsy. She suffered a number of fits at Downview and, in early 2011, the doctor decided to try a different drug to control her fitting.
4. During her time in prison, the woman had developed close relationships with some other women prisoners. One woman whom she had planned to live with had been released, but was murdered on 14 March 2011. She was greatly upset by the news and staff began to monitor her under suicide and self-harm monitoring procedures. On 24 March, staff met to review these observations and reduced the number of checks, so that she was observed only during the night time lock up. Safer custody staff questioned this decision and thought that she would benefit from recorded interactions with staff during the day. Following this advice, the case manager planned to review the level of observations at the next review on 30 March.
5. A few days later the woman went to work and also met her psychiatric nurse. She gave no indication that she planned to harm herself. Her self-harm monitoring review had been scheduled for the morning, but the case manager re-arranged it for the afternoon. Before the prisoners were locked up for lunch, one of her friends asked an officer to check her because she was worried. He did so sometime between 12.30 and 12.40, when she said she did not want additional checks.
6. At about 1.40pm, the officer in charge of the woman's landing began unlocking the cells for the afternoon. She did not look into the woman's cell as she was supposed to when she unlocked her. Shortly after her friend, who had expressed her concerns before lunch, opened the door and found her suspended by a length of torn bed sheet. She screamed at the shock, and the landing became chaotic. Staff radioed for help, but used the wrong call

signs on their radios so other colleagues were not aware of the nature or seriousness of the incident. Nonetheless, healthcare staff attended the scene and two ambulances and a helicopter air ambulance arrived at the prison shortly afterwards. Despite efforts to resuscitate her, she was pronounced dead at 2.29pm.

7. We make 17 recommendations as a result of the investigation. In particular, we have asked the Governor to improve the way in which the ACCT self-harm monitoring process is managed. We were also concerned about the poor management of the response to the emergency, about which we make a number of recommendations.

THE INVESTIGATION PROCESS

8. The Ombudsman's office was notified about the woman's death on 30 March 2011. An assistant Ombudsman visited HMP Downview on 4, 6 and 8 April. During her visits, she met, amongst others, the Acting Governor, representatives from the Independent Monitoring Board (IMB), Prison Officers' Association (POA), the Head of Reducing Re-offending, Head of Healthcare, Staff Care Team Leader and the Senior Officer from the Safer Custody Department.
9. The assistant Ombudsman toured the prison and saw the landing and cell where the woman died. She spoke informally with staff and prisoners. There was a large volume of documents, and she reviewed them over the course of the three days she visited, so that Downview staff could then prepare them for the investigation.
10. The investigator conducted interviews, along with other PPO colleagues, on several occasions between 12 July and 17 November 2011. After the initial interviews, he wrote to the Governor highlighting the emerging findings. The clinical reviewer completed a review of the woman's clinical care on behalf of the local PCT. The report of the review was received in January 2012. The delay in issuing this investigation report is regretted. This was mainly due to workload pressures on the part of the investigator

The woman's family

11. One of the Ombudsman's family liaison officers and the investigator visited the woman's mother and her sister on 24 May 2011, to explain the investigation process and to allow her family to raise any issues they had about the care she received during her prison sentence. Her mother said that her father had taken his own life some fifteen years earlier and that the anniversary was approaching. However, she did not think that this would be a reason for her daughter to take her own life. She also said that her daughter had a history of self harming from an early age.
12. The woman's sister told the family liaison officer that her sister had phoned her after the murder of her friend. She said her sister was in tears and screamed and cried and said she was going to kill herself, but when she spoke to her again, two days later, everything seemed fine.
13. The woman's mother also raised the following issues which are addressed in the report:
 - She was confused as to how her daughter had managed to hang herself from such a low point.
 - Had she self-harmed previously during her sentence?
 - Had she given permission to the prison for her general practitioner (GP) records to be obtained?
 - Why she had been locked up over the lunch time period between 12.30 and 1.30 but was not discovered until 1.50pm?

- Was she placed on suicide prevention monitoring after the death of her partner?
- The mother and sister both felt that they were treated badly by the prison family liaison officer. They considered him insensitive and matter of fact in his liaison. They said that an officer had told them they could not speak to the Coroner and would not receive a copy of the Ombudsman's report until the inquest.
- What medication was she prescribed in prison?
- Why was she placed in a single cell?
- The mother was also concerned that letters cards and other documentation in her daughter's cell took too long to be returned to the family.

HMP DOWNVIEW

14. HMP Downview is a women's prison in Sutton, Surrey, on the outskirts of London. The prison holds a maximum of 359 women. At the time of the woman's death, this number had been significantly reduced by nearly 100, owing to building works. All but two cells are single. The prison has a resettlement unit for 40 women prisoners, who mostly work in the community. Healthcare services are commissioned by the NHS and provided by Surrey Community Health. Mental Health Services are provided by Surrey and Borders Partnership.

Her Majesty's Inspectorate of Prisons

15. The Inspectorate of Prisons completed a full inspection of Downview in 2008. In relation to suicide and self harm, inspectors noted that there had not been a death at the prison for nearly five years and levels of self harm were relatively low. However, the recording and support for women at risk of self-harm was variable and inconsistent. The report commented that staff had not received refresher training in the ACCT suicide and self-harm monitoring procedures, and that only half of senior officers had received case manager training. The Care and Management Plan section of the ACCT documents were not always completed or properly reviewed. The report recommended that local instructions on suicide prevention should be rewritten to reflect the specific needs of women.
16. An unannounced short follow-up inspection took place in September 2011, six months after the woman died. In 2010 and 2011, the prison experienced significant difficulties after some of its staff were accused of using their positions to form inappropriate relationships with prisoners. The prison attracted a considerable amount of media attention and Surrey Police launched an investigation. (We discuss this later at the start of the 'Issues' section of the report. There is no evidence that the woman was directly affected by these events.) The Chief Inspector commented:

"This follow-up inspection took place at a very unsettled time for the prison. In 2010 a number of serious allegations had been made against some managers and staff. There had been significant changes to the senior management team and a number of management challenges. Not least among these were the very low staff morale and staffing shortages, combined with a high proportion of staff who, for a number of reasons, were unable to carry out the full range of prison officer duties.

"At our inspection in May 2008 the prison was generally safe... There was little indication that bullying or use of illegal drugs was a major problem ... There was reasonably good support for women at risk of suicide and self-harm and some good services to help women with substance use problems had been provided with the introduction of the integrated drug treatment system.

“Unsurprisingly the misconduct of a small number of staff had impacted on the quality of relationships between officers and prisoners with some degree of distrust on both sides. Nevertheless, we saw generally positive interactions. The number of male officers almost equalled the number of female officers, and this was too many for a women’s prison.

“Fundamentally Downview has the potential to be a very good women’s prison. It has a generally settled population, relatively low levels of self-harm and a decent range of activities to keep women occupied. Our 2008 report indicated reasonably good outcomes for most prisoners, despite the lack of effective management structures to support some outcomes, but the previous senior management team appeared to have done little to implement our recommendations. Further opportunities to drive forward progress were derailed when allegations were made against staff and management attention focused on dealing with these.

“There are signs that the prison is beginning to get through this crisis, but it needs a period of stability in staffing and management to allow it to build on its strengths and drive through improvements.’

In relation to suicide and self harm the report noted that levels of self harm had reduced and there was reasonable support through counselling services and Listeners. However, ACCT procedures still needed to improve and there was little consistency of case management or multi-disciplinary representation at case reviews. Too many staff needed ACCT training.

Independent Monitoring Board

17. The most recent annual report published by the Independent Monitoring Board (IMB) at Downview covers the year 2011. (The IMB at each prison is made up of unpaid members of the local community who monitor the day-to-day life in prisons to ensure that proper standards of care and decency are maintained.) The IMB wrote:

“One of the principal aims of prison is to reduce reoffending, but we do not see how policies to achieve that purpose can be successfully implemented until organisational and staffing issues are addressed. As HMIP has recently observed, there are areas of excellence in Downview, but we believe that the overriding problem during this difficult year has been the absence of friendly interaction and mutual trust between management, unions and operational staff. Morale has consequently suffered.”

Previous deaths at Downview

18. Before the woman, Downview had not had a self-inflicted death since 2003. This was before the Ombudsman was given responsibility for investigating all deaths in prison custody. The only previous death at Downview investigated by this office was due to natural causes in 2004.

KEY EVENTS

19. The woman had a history of alcohol misuse and intravenous heroin use, as well as mental health problems. Her father had taken his own life around fifteen years previously. She had a young daughter who her mother cared for. She had previously been the victim of domestic violence and also disclosed to staff that she had been raped.

2010

HMP Bronzefield

20. The woman had served a previous custodial sentence and was released from HMP Downview in January 2010. In early April, she committed a further offence of armed robbery in a supermarket. Her accomplice was someone with whom she had apparently begun a relationship with during the recent custodial sentence.
21. The woman was remanded into custody and taken to HMP Bronzefield on 16 April. A Cell Sharing Risk Assessment (CSRA) indicated she should not share a cell because of her alleged offence. In July, healthcare staff at Bronzefield recorded that she had been maintained on 40mls of methadone since May.
22. On 12 August at Crown Court, the woman received a 32 month custodial sentence for the offence of armed robbery and three offences of shoplifting.

HMP Downview

23. On 19 August 2010, the woman transferred to Downview. She was assessed by a nurse during the reception process. The nurse was unaware of any previous history of self-harm and noted that she had no active suicidal thoughts. The nurse noted previous diagnoses of borderline schizophrenia and a personality disorder, and referred her for a mental health assessment.
24. A Senior Officer (SO) completed a new CSRA and assessed the woman as presenting a low risk of harm to potential cellmates and suitable to share a cell. The SO recorded her possible diagnosis of a personality disorder and her mental health issues on the CSRA.
25. The next day, 20 August, a doctor assessed the woman. He recorded her history of intravenous drug use. He also noted that she had just received a much longer sentence than she had ever previously served. He took account of her psychiatric history. The doctor also wrote that she suffered from epilepsy. He recorded that she had apparently had a lump in her abdomen which had been treated at hospital.
26. The doctor and the woman discussed her medication. He decided that she should continue to receive the same medication as at Bronzefield; mirtazapine (an antidepressant), quetiapine (an antipsychotic drug used to treat high and

low moods) and clonazepam (a benzodiazepine used to treat epileptic fits). The doctor also asked staff, after getting her consent, to obtain her GP and hospital records.

27. The woman attended a substance misuse assessment with a nurse from the Integrated Drug Treatment System (IDTS) team on 24 August. He recorded that she was currently prescribed 60ml per day of methadone. There is no record of when or why the dosage of methadone was increased from the 40mls prescribed at HMP Bronzefield. She said that she wanted to complete a detoxification programme.
28. On 26 August, the woman had a fit. Two days later, on 28 August, when a doctor saw her, he recorded that she was prescribed 40mg of methadone. He encouraged her to engage with the mental health in-reach team (MHIRT) for support. (MHIRTs treat prisoners who have severe and enduring mental health problems, such as schizophrenia.)
29. On 2 September, a nurse from the IDTS team completed a mental health assessment with the woman. She recorded a history of self-harm and attempted suicide. The woman told her that she had thrown herself off a building when she was 17, and had cut her wrist in prison the year before. She said that she had never tried to take an overdose.
30. The woman said she heard voices, including that of her late father. She did not want to contact her family and said she did not want to talk about them either. She had apparently been admitted to a mental health unit in Margate in the past. The nurse noted previous diagnoses of split personality disorder and schizophrenia and wrote that her mood could be very up and down and she could become tearful. She denied any current suicidal thoughts. The nurse noted that her case would be discussed at the next in-reach meeting. She thought that she seemed depressed.
31. A community psychiatric nurse attached to the MHIRT sent the woman an appointment for 8 September, but she did not attend. On 13 September, she was accepted onto the MHIRT's caseload. The same day, she saw a doctor. She told him that she wanted to start a managed withdrawal from methadone. He agreed that she would reduce 5mg per fortnight, from 40mg to 20mg. (The previous record said she was on 40ml.)
32. On 14 September, a doctor wrote in the clinical record that the woman would need to be weaned off clonazepam because this drug was not one normally prescribed for epilepsy at Downview, and a different medication to control her fits should be used. On 17 September, she missed a second appointment with the community psychiatric nurse. He queried the missed appointments, and was told that, when offered such help she tended to withdraw. He said he then persevered in order to get her to engage. The same day, and also on 24 and 26 September, she was caught by nurses trying to conceal, rather than swallow, her medication.

33. The woman met her offender supervisor (a prison-based probation officer) on 21 September. The offender supervisor suggested that she ask to be referred to the Counselling, Assessment, Referral, Advice and Throughcare service (CARATs) team (which works with substance misusers), the MHIRT and the Thinking Skills Programme (TSP). The TSP is a group course to help prisoners learn skills aimed at improving their decision-making and avoid offending.
34. On 28 September, the woman attended the substance misuse clinic. She saw a doctor the next day. She told the doctor that her 7 year old daughter was now aware she was in prison because of her drug use. She wanted to complete her withdrawal from methadone as she wished to re-establish contact with her daughter. On 5 October, she met a nurse, who recorded that she had now reduced her daily methadone intake to 25ml. (This was a faster reduction than previously suggested.) She also told the nurse that she had had positive experiences of drug withdrawal using Subutex in the past. Following a consultation with a doctor on 6 October, and at her request, she changed to a reducing dose of Subutex, rather than methadone.
35. On 15 October, the community psychiatric nurse met the woman when she attended the third appointment he had offered her. He referred her to a psychiatrist, who assessed her on 19 October. The psychiatrist recorded her history of depression, personality disorder, drug misuse, and deliberate self-harm and suicide attempts. He planned to review her six to eight weeks later.
36. The same day, the woman was assaulted, and had a black eye and scratches. Staff suspected three other prisoners, and an involvement in trading of mobile phones and drugs. On 16 October, an officer questioned her about the assault, and she said she had had a disagreement with another prisoner, but that the issue was now resolved.
37. The community psychiatric nurse met the woman again on 22 October. She told him that her detoxification programme was too rapid for her, and he asked her to speak to a nurse about this. She told him that she had found her recent session with the psychiatrist unhelpful.
38. On 23 October, nurses suspected that the woman was concealing her Subutex in the roof of her mouth rather than swallowing it, so that she could then sell this medication to another prisoner. They notified a nurse from the IDTS team. He met her to assess the situation on 26 October and decided that she needed to be closely supervised when given her medication at the dispensing hatch because of her repeated attempts to conceal it.
39. The nurse also considered returning the woman to methadone (a liquid rather than a tablet) to help her withdraw, so that she would not be able so easily to conceal and trade the drug. He told her that she would receive a written warning if she continued to try to conceal medication. A few days later, on 30 October, she again tried to conceal her medication rather than swallowing it. From this point onwards, two staff observed her while she took her detoxification treatment.

40. On 2 November, staff suspected that the woman was under the influence of drugs. She seemed unsteady on her feet and was slurring her words. The next day, 3 November, a doctor spoke to her and stressed that her attempts to conceal her medication contravened the agreement she had made with staff to help her withdraw from drugs. She became tearful during the conversation. The same day, she met the community psychiatric nurse. They scheduled an appointment for a fuller assessment.
41. Two weeks later, on 17 November, the community psychiatric nurse saw the woman. She acknowledged that recent bruising on her face had been caused by a fight and not an epileptic fit. She said that she felt more settled now that she had moved wings. There is no record of either the date or reason for the move. She had spoken to a member of the CARATs team and was considering the possibility of a visit from her young daughter.
42. The woman attended an IDTS review with a nurse on 22 November. Her dose of Subutex was still being gradually reduced. She told him that her mirtazapine was not having the effect it was supposed to, so the nurse contacted the MHIRT. Two days later, on 24 November, the community psychiatric nurse assessed her. She told him that she was being bullied on the wing. He told her that she needed to tell wing staff about her concerns. He made a plan to refer her to a mental health in reach worker and requested that a psychiatrist review her medication.
43. On 27 November, the woman had another fit. On 8 December, a doctor saw her at the substance misuse clinic. She was nearing the end of her detoxification programme. She was angry that her prescriptions for quetiapine and clonazepam had apparently been reduced. She became tearful and told the doctor that she “doesn’t want to be like this anymore”.
44. A nurse spoke to the community psychiatric nurse after the substance misuse clinic. He saw her the same day and discussed her concerns about her withdrawal from drugs and her reduced prescriptions. She mentioned that her partner might be transferring to Downview from HMP Bronzefield. She confirmed that she was not having any suicidal thoughts, but she appeared very stressed and angry. He recorded that she “does not feel she can cope”. She told him that the substance misuse team were not listening to her. He advised her to stay calm and not to become aggressive when she discussed her treatment with the IDTS staff.
45. On 22 December, the woman completed her detoxification programme. The following day, 23 December, she saw the community psychiatric nurse again. She was still under the impression that her prescription for quetiapine had been reduced, although this was not the case. She said that she was struggling to manage her anger. However, she said that she was not having any suicidal thoughts and he thought that she seemed to be coping better. He referred her to a psychiatrist to review her medication.

46. At the end of December, staff recorded suspicions that the woman was being threatened by two other prisoners. Staff completed a Security Information Report (SIR) and assessed the risk to her. The prisoners suspected of threatening her were placed on behaviour monitoring and the matter was reviewed and closed 10 January 2011.

2011

47. A doctor assessed the woman on 6 January 2011. He decided to reduce and then end her prescription for mirtazapine and start a prescription for a different antidepressant, fluoxetine. He also considered the possibility of giving her night time dose of quetiapine in-possession (retained in her cell) so she could take it before she went to bed to help her sleep better. He diagnosed mild to moderate depression in combination with a borderline personality disorder.
48. An officer completed an OASys risk assessment of the woman on 9 January. (OASys is a risk assessment tool used by probation and prison staff. It uses information about the offender's behaviour in the past to determine the likelihood of further offending and the risk the individual presents to others.) The officer recorded that there was no evidence to suggest that she might take her own life.
49. On 12 January, the community psychiatric nurse saw the woman again. She told him about her plans to move to Maidstone when she was released. She was now working in the prison kitchen. She had recently tested negative for drugs following her successful withdrawal. She told him that she was not having any suicidal thoughts.
50. On the same day, a prisoner transferred to Downview. It appears that some time later the prisoner and the woman began a relationship.
51. The following day, 13 January, the woman had another fit. A doctor saw her and recorded that the plan to stop her mirtazapine prescription and switch to fluoxetine (a different antidepressant) should proceed. On 18 January, another doctor saw her. He recorded that she was still suffering fits. He noted that she should be weaned of clonazepam and switched to a different drug, lamotrigine, to manage her epilepsy.
52. The community psychiatric nurse assessed the woman again on 26 January. She had recently completed a CARATs course. She was hoping to be released in April under the Home Detention Curfew (HDC) electronic tagging scheme. She mentioned that her new partner had been released and she was waiting to hear from her. The nurse recorded that there were no major complaints from her following her change in antidepressant medication. She told him that she was not having any suicidal thoughts.
53. At the end of January, staff suspected the woman of being under the influence of heroin. On 1 February, she saw a doctor. He recorded that she was currently prescribed quetiapine, fluoxetine, a reducing dose of clonazepam and lamotrigine. He assessed her on 3 February. He agreed that her

prescriptions should continue. He noted that she was not having any suicidal thoughts. She was allowed to make a telephone call to her accomplice at Bronzefield on 4 February.

54. The community psychiatric nurse met the woman on 11 February. She seemed less positive than she had been, but said she was not having any suicidal thoughts. She was unable to sleep and was becoming stressed. A doctor assessed her the same day and prescribed a three-day dose of zopiclone (a strong sedative) to help her sleep.
55. The woman saw a doctor on 15 February. She asked for mirtazapine. He recorded that she had been prescribed fluoxetine (as an alternative) and zopiclone recently and would not receive any more mirtazapine until she underwent a further psychiatric review.
56. The next day, 16 February, the woman told a nurse that she felt very tired and low in mood. The same day, the woman's accomplice transferred to Downview from Bronzefield. She moved into a cell on the third landing of C wing south, above the woman, who was living on the second landing. After she arrived, they seemed to have resumed their relationship. The woman's new partner told the investigators that she ended her relationship with her because she was scared of repercussions from the accomplice. However, she also said that she had subsequently restarted her relationship with her in secret at some point before she died. On 17 February, the woman began the TSP.
57. A nurse from the IDTS team assessed the woman on 20 February. She told him that she was now misusing Subutex that she had illicitly obtained from other prisoners. She said that she had stopped taking drugs for about four weeks after completing her detoxification programme in December, but had recently relapsed. The nurse decided to liaise with someone from the CARATs team. He considered the possibility of her being prescribed methadone again.
58. On 3 March, a doctor assessed the woman because of her recent fits. He endorsed the decision by nurses to stop her working in the kitchen. He considered referring her to hospital, but wanted to read her historical records from another hospital first. These records apparently made reference to a "shadow on her brain". Healthcare staff requested the records from the hospital the same day. On 7 March, she asked to return to work in the kitchen, but was told that she would need to for a period of at least three weeks before this could be considered.
59. On 8 March, a facilitator on the TSP, who knew the woman had previously suffered from an eating disorder, reported concern about her weight loss. The healthcare department indicated that there were no current concerns about her health. She fitted during that day's TSP session.
60. On 11 March, the woman was unable to attend an appointment with the community psychiatric nurse because she was attending the TSP. The same

day, an officer found her in her cell with her partner. (Her partner was her co-defendant in the offence of armed robbery.) The door was pushed to and a desk was placed behind it to prevent entry. The two women were described as in a state of undress. The officer issued both women with a warning. She noted that they appeared to be in a relationship, and observed the two women behaving amicably with each other later in the day.

61. However, other staff were concerned about the nature of their relationship. On the same day, 11 March, they recorded that the woman was afraid of her partner. While attending the TSP, she told the facilitator that her partner had threatened to cut her with a blade if she went ahead with a visit from a former partner, who had recently been released from Downview. The two women had apparently been planning to live together in the community once she was released.
62. The woman told the facilitator that her partner was her *former* partner. Security reports also detailed how her partner had apparently suggested to her that she could arrange for someone to assault her ex-partner outside the gates of the prison if she visited her. Following receipt of this information, staff completed SIRs and planned to inform the wing manager and the violence reduction coordinator. Downview's police liaison officer was informed and all reports were shared with local police. Although it is recorded in the SIR that agreed actions were completed, the relevant section of the document does not show that the wing manager was informed of this latest information. Despite her partner's alleged threats, the ex-partner visited her on 12 March.
63. Two days later, on 14 March, the woman's ex-partner's body was discovered in a flat in nearby Sutton. She had been murdered. The woman found out the news the same day when she spoke to her ex-partner's father on the telephone. The police later ruled out any connection between her current partner's earlier threats and the subsequent murder.
64. The officer who was the woman's personal officer for the four months prior to her death recalled her making the telephone call to her ex-partner's father. The officer had been monitoring the dinner queue when she suddenly heard screaming. She told the investigators that the woman ran crying in distress from the telephone to the showers. She followed her into the shower room and found her on the floor shaking and crying. The officer stayed with her for a while and then asked a couple of her friends to sit with her.
65. The officer completed a 'Concern and Keep Safe' form to begin monitoring under the Assessment, Care in Custody and Teamwork (ACCT) suicide prevention and self-harm management procedures, at 6.30pm that evening, because she was concerned that the woman needed additional support after receiving the news about her ex-partner's death. She knew that she had made previous attempts to harm herself. She told the officer that she did not know what she was going to do, or how she was going to cope, after hearing about her death. She did not say that she was thinking of taking her own life.

66. The 'Immediate action plan' section of the ACCT document was completed by a SO at 2.30pm the following day, 15 March. It was agreed that the woman would remain in her own cell and would be given access to the telephone as required. She was also made aware of and offered the support of Listeners who are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress. The chaplaincy and CARATs departments were also noted to provide support.
67. The officer also went around the wing making sure that some of the other women who had been affected by the death were coping. The woman was checked by staff at least every half hour until an ACCT assessment interview could be arranged. (This interview should take place within 24 hours of ACCT self-harm monitoring starting.) She telephoned her sister for support that evening.
68. An officer completed the ACCT assessment interview with the woman at 10.45am the following morning, 16 March. He told the investigators that she responded to all his questions and, while upset, did not seem "overly depressed". However, she told the officer that she had experienced suicidal thoughts. She said that she had not planned how she might take her own life, but indicated that she would not tell staff if she decided to do so.
69. The SO, an officer, a member of the CARATs team and the woman met for the first ACCT case review at 2.35pm that afternoon. She was very low in mood and tearful. She was still in shock. Those present suggested that she might consider counselling to cope with her grief. The SO assessed that there was currently a raised (or medium) risk of her harming herself. Following the review, wing staff were required to check her twice hourly 'in patrol state' (day and night) and record conversations with her. During the night, staff recorded movement on a dedicated 'tick box' sheet but made no written entries in the ACCT document. Three almost identical goals were set in the Care Management Plan (Caremap) – "to deal with grief".
70. The woman wanted to attend her ex-partner's funeral and staff completed an application for her release on temporary licence (ROTL) the same day, 15 March. The chaplain arranged for her to light a candle in the chaplaincy later that day in memory of her ex-partner. A doctor prescribed her zopiclone to help her sleep. After her ex-partner was killed, staff decided to remove her temporarily from the TSP because she was not sufficiently resilient to cope with the group environment.
71. On 22 March, staff discovered the woman's medication in another prisoner's cell. The following day, the community psychiatric nurse assessed her again. She said that she planned to speak to her daughter on the telephone later that day, and denied any suicidal thoughts. He recorded that she seemed subdued but "managed the occasional smile". She was prescribed diazepam (a sedative). He decided to review her in a week's time.
72. A doctor assessed the woman on 24 March. The consultation focussed on her fits. The doctor decided that she could return to work in the kitchen. He

told the investigators that he did not recall discussing her mental state with her during the appointment.

73. A SO led an ACCT review on the same day, 24 March. The woman and a Support, Time and Recovery (STR) mental health worker were also present. The SO wrote:

“She is slowly starting to feel better in herself and has come to terms with the issues ... The review board has decided to change observations to evenings, from 20.00 hours to 08.00 hours at one per hour, as these are the times she is at her lowest.”

74. ACCT observations were reduced to the night time only, with no requirement for staff to check the woman during the day. The SO told the investigators that all present had spoken in depth during the review about the recent death of her ex-partner. He explained that at the review it had been agreed that she was not vulnerable during the day, because she was working and did not need to be checked. She had said that she found it more difficult when she was locked up for the night and had occasional thoughts about harming herself because she had too much time to think. The next ACCT review was scheduled for 10.30am on 30 March.

75. A SO performed a management check on the woman’s ACCT document on 27 March. He wrote: “two times hourly conversation”. He accepted during interview with the investigators that his entry was an error, as it did not tally with the expected level of observation set at the recent ACCT review.

76. A prisoner, who lived in the neighbouring cell to the woman, told the investigators that the woman said a few days before she died that she wanted “to join her girlfriend”. Another prisoner also told the investigators that she had repeatedly said that she wanted to “go and be with her”.

77. On 29 March, the woman asked staff to telephone her ex-partner’s family to find out the date of her funeral. They did so but got no answer. The governor in charge of safer custody checked her ACCT document the same day. She wrote that the review due the next day should focus on updating the Caremap. (The Caremap sets out the problems the prisoner faces which have prompted ACCT monitoring and the measures being taken to help resolve these issues.) SO A (the suicide prevention coordinator) added the following comment to the management check for that day:

“Re: obs – what is level of risk during any other period of lock up?”

78. SO A emailed SO B, the ACCT case manager, at 8.01pm the same evening:

“I checked [another prisoner] and the woman’s ACCTs this evening. I see you have noted risk is low therefore only night obs/patrol. Which is great. My thoughts are would a day time check be in order also, maybe once am and pm, so we can ascertain whether there are any further risks/issues. As with all ACCT observations it needs to be clear

as to what the level is at specific times of the day; risks tend to be greater at night hence higher obs but less when at work etc... The current obs level could cause confusion for staff managing them, as in 'Do I check her during the day?'"

Events leading up to the incident

79. An officer checked the woman at 8.00am and 8.30am the next morning. He recorded both observations in the ACCT document. He saw her leaving the wing to go to work that morning and later returning from work at lunchtime. He told the investigators that she seemed fine on both occasions. A nurse later recalled in her statement that she collected her morning medication from the dispensary as usual before going to work.
80. SO B replied to SO A's email at 8.27am that morning:

"In my defence, the woman's ACCT was only opened because of the death of her ex-partner, she had no self harm issues, when I reviewed her she was happy that as she was at work all day she had no thoughts, but found it difficult during the night."
81. The community psychiatric nurse met the woman to complete a planned mental health review at about 10.30am that morning. She said that she was enjoying being back at work in the kitchen. She explained that she was about to find out if she was going to be released as part of the HDC electronic tagging scheme. She said that she was getting more sleep and that her appetite had improved. She described how supportive some of her fellow prisoners had been. She was still waiting for details of the funeral. He recorded that the "risk to self" was currently low and that there was no evidence that she might want to deliberately harm herself.
82. The psychiatric nurse told the investigators that he had looked back at his appointment with the woman many times since her death, and could not think of anything she had said which would have caused him additional concern. She seemed the same as usual. He thought that she was positive about withdrawing from drugs. He did not think that she had been masking any significant anxiety. He planned to meet her for another review a week later. He told her to keep busy working in the kitchen and going to the gym.
83. SO B explained during interview that he had been very busy that morning. He had attended a training session with the governor in charge of safer custody. The woman's ACCT review was scheduled for 10.30am, but he said he spoke to her before she left for work and suggested that, instead, they sit down during the afternoon to complete the ACCT review. She agreed. He did not record this conversation in the ACCT document neither is there any evidence to suggest that the mental health worker had been informed of the new time for the review.
84. SO A emailed SO B again at exactly midday:

“My main concern with this stems from a serious issue we had last year when we had another prisoner subject only to night obs, which led to no checks being done at all over a number of days!! Of course we have moved on from then and we are getting much better at identifying risk and how we manage that individual.

“... the circumstances of those only subject to night obs: the main point for me is our justification (with inclusion of the prisoner) and that it has been clearly documented so all others who have contact with that prisoner know what is happening. I am sure there will continue to be entries made by staff during the day, which is not a bad thing, maybe they just need some clarification as to what exactly managers require from them, be it a quality entry in the morning and one in the afternoon. This of course can be at your discretion dependent on what type of feedback you require in order to manage the risk and complete follow-on ACCT reviews.”

85. A prisoner told the investigators that the woman was not her usual self that morning and had seemed subdued. Another prisoner told the investigators that she looked into her cell at about 11.30am when she returned from work. She was sitting on her bed talking to another prisoner. The prisoner recalled during interview that she had asked her if she was OK. She remembered that she had said that she was, but she thought it clear from her demeanour that she was not.
86. Another prisoner also visited the woman's cell. She asked the prisoner to open up her bible, which was on the windowsill. The prisoner later told the investigators that the woman had also received a letter about her ex-partner, which seemed to have upset her. She was the last prisoner to speak to her before they were locked up for lunch. (Security information, recorded after her death, indicates that she told the prisoner that she was going to “do it” over lunchtime.)
87. Another prisoner who was friends with the woman approached Officer A as he was locking up the prisoners for lunch. She asked him to check the woman because she seemed down. She expressed concern to the officer about the impact that the ex-partner's death and other matters were having on her. She later gave a statement supporting another prisoner's assertion that the woman had received a letter that morning. It was suggested during interviews with prisoners that the letter may have contained information that her ex-partner was killed while trying to obtain drugs to bring into prison for her, causing her to feel guilty. (Such a letter was not found during the investigation.) The prisoner told the investigators:

“...over dinnertime she wasn't herself... I knew something wasn't right with her, that's why I told the officers that she needed to be watched because she had said that she didn't want to be here anymore and that she wanted to be with her ex-partner.”

88. The prisoner told the investigators that the woman had said this before the women were locked up for lunch. She spoke to her through the observation hatch because the woman had already been locked up for lunch. She recalled during interview:
- “... [I] asked her if she was OK and she said no and she was like pacing in her room. That’s when I said to the officer you need to watch her carefully...”
89. At 12.15pm, Officer A went to the woman’s cell and spoke to her. He asked if she was alright and whether she wanted staff to carry out extra checks on her. She was sitting on her bed and looking out of the window. She told the officer that she was fine and did not require additional observations. He made an entry in the ACCT document about his conversation with her, “Returned from work not in a good mood but said she didn’t want obs upped”.
90. Officer A asked Officer B, who was working the lunch patrol shift, to keep an eye on the woman. He told him what the prisoner had said to him about her, but also explained that he had checked her and she had said she was fine. He then went to lunch and later returned to the landing below, where he normally worked.
91. By about 12.30pm, all the prisoners had been locked up for the lunch period. (The woman lived in cell 1, a single cell on the south part of the second landing of C wing.) A short while later, Officer B went to check all the prisoners who were currently subject to ACCT monitoring. Although Officer A had mentioned the woman specifically, he told the investigators that he always checks prisoners on ACCT documents after a handover between staff, no matter how frequently each ACCT document indicates that the individual should be observed.
92. When Officer B checked on the woman at 12.40pm, she was sitting on the floor at the foot of her bed, near the door. The bed was on the right hand side of the room. She was leaning against it with her legs out in front of her parallel to the back wall. He asked if she was “all right”. She looked up, nodded and looked back down again. The officer told the investigators that he made eye contact with her. He remembered during interview that she was not showing any signs of distress, was not crying and did not look upset. He made a brief record of his observation in the ACCT document: “Sat on floor looked up when checked”.
93. SO B replied to SO A’s latest email at 12.50pm:
- “All your comments noted, I will inform my staff.”
94. During interview, SO B explained that he had planned to consider additional ACCT checks during the daytime when he completed the woman’s ACCT review later in the afternoon.

95. During the lunchtime lock up, a prisoner shouted out to the woman, asking if she was all right, but got no reply. She was concerned that she was so quiet, because she usually watched television or listened to the radio, or talked to her through the wall.
96. At 1.30pm, Officer C started her shift. At 1.40pm, she began unlocking the prisoners on the south part of the second landing on C wing so that they could go to work. She was the only officer on the landing at the time. She unlocked the woman's door first, then proceeded along the right-hand side of the landing before coming back along the left-hand side. She did not look inside the woman's cell through the observation hatch when she unlocked the door. Before turning the key, staff are supposed to check the prisoner as a matter of routine for their own and the prisoner's safety. She unlocked each door and moved straight onto the next one.
97. One of the last prisoners to be unlocked from her cell, because she had been concerned, went straight to the woman's cell and pushed open the door to speak to her. At this point, a few minutes had passed since Officer C started to unlock the cell doors, because some of the women had already left the landing to go to work.
98. The prisoner opened the door and witnessed the woman slumped on the floor right at the back of the cell with a length of torn sheet around her neck. She lay facing the door with her legs straight out in front of her. The prisoner screamed and collapsed to the floor. The woman had attached the sheet to heating pipes that ran below the cell window perhaps six or eight inches off the floor. Officer C immediately joined the prisoner at the cell door and used her radio to request healthcare assistance. She told the investigators that she gave her location and entered the cell.
99. Officer A could hear the prisoner's loud screams and immediately came up the stairs from the landing below. He joined Officer C in the cell. She was already on her knees by the woman, attempting to support her shoulders and relieve the strain on her neck. Officer A produced his cut-down tool and cut the sheet from around the woman's neck. He told the investigators that he then used his radio to ensure that control room staff correctly understood their location and that this was a 'Code 1' emergency requiring an immediate response from healthcare staff. (There is no record of this call in the control room log.)
100. The officers then began to perform cardiopulmonary resuscitation (CPR). Officer C was carrying a protective mouth guard on her belt so she gave breaths to the woman while Officer A gave chest compressions.
101. SO B was outside C wing overseeing the movement of the women to their workplaces when he heard the prisoner's screams. He hurried back to the woman's cell, pushed the cell door open, confirmed that the two officers were attempting CPR and pulled the door to again to stop the other prisoners from witnessing the emergency. As he was not first aid trained he did not participate in the CPR.

102. At 1.45pm, the SO radioed the control room to say he required assistance on "C 2 South". This call did not state the exact location of the cell or the nature of the emergency. At this point, the orderly officer for the day, a DPSM, was informed of an incident. At 1.47pm, the SO used his radio to inform the control room of a "Code 3 incident" and asked healthcare staff to attend "C 2 South". This was the least serious and, therefore, the wrong code to use. The SO acknowledged during interview that he used the wrong code because he was used to a different code system when he had worked at HMP High Down. The Head of Healthcare told the investigators that a "Code 1" call (the correct code to use for a hanging) was not transmitted over the radio network.
103. The SO told the remaining staff to lock the prisoners who were still on the landing back in their cells. He stayed outside the cell door, which was slightly ajar, directing the women either back to their cells or to their work. The women became distressed and a number of staff described the scene on the wing as chaotic.
104. Officer B had returned to the third landing after the lunch patrol. He heard a general alarm over the radio and went down to the second landing, where he was directed to the cell by a prisoner. He pushed open the cell door and saw the SO with both officers, who were performing CPR. The SO asked Officer B to help perform CPR. The officer took over from Officer A giving compressions.
105. A Physical Education Officer (PEO) arrived on the wing from the gym. She was directed to the cell by the prisoners. She recalled during interview that the women had become hysterical and were refusing to move off the landing. She went into the cell, closed the door behind her and offered to assist with CPR. She was first aid trained and offered to take over from one of the officers, but they carried on. She sat on the bed and started writing a log of the emergency, before eventually taking over from Officer B giving chest compressions. The SO asked another SO to continue recording a log of events at the scene. The staff continued to rotate performing compressions. Officer C found it difficult to get out of the cell once she was relieved because of the lack of space and the amount of furniture and people.
106. The nursing staff were in the healthcare centre having a handover meeting when the emergency began to be relayed across the radio network. The nurses, joined by the Head of Healthcare, collected the healthcare emergency response bag and a defibrillator and headed for C wing. (A defibrillator is a portable machine which can deliver an electric shock to reset an irregular heart rhythm. However, it is only able to do so if it can find a rhythm to begin with.) The Head of Healthcare told the investigators that it took her and her colleagues about three minutes to reach the cell.
107. When the healthcare staff arrived, they took over CPR. The Head of Healthcare instructed the officers to request an emergency "999" ambulance. Officers contacted to control room to convey her request at 1.49pm. The

ambulance service recorded a telephone call from the prison at 1.51pm. An ambulance was dispatched at 1.57pm.

108. As the healthcare staff received the wrong code over the radio network, they did not bring enough oxygen with them because they did not think they were responding to a prisoner who had been found hanging. The Head of Healthcare was asked by a colleague to radio healthcare and arrange for more oxygen to be brought to the cell as a precaution.
109. At about 2.00pm, healthcare staff thought that they might have found a pulse. A nurse applied the defibrillator pads to the woman's chest; another gave oxygen using an inflatable bag and mask. The Head of Healthcare supported the woman's head and maintained her airway. The nursing staff used the defibrillator but the machine indicated that it was inappropriate to deliver an electric shock and that the nurses should continue to perform CPR.
110. A DPSM was in charge of the emergency on C wing. She reached the cell at 1.50pm. Two operational managers also attended the wing and suggested to the duty manager that he open the command suite to coordinate the emergency. Officers A and C went to sit in the SO's office after they left the woman's cell. They were joined by a member of the prison's care team.
111. Two different ambulance crews arrived at 2.02pm and 2.05pm. One of the ambulance crews accidentally headed for neighbouring prison, HMP High Down, before correcting their mistake. The first paramedics reached the wing at 2.04pm and continued CPR. At 2.19pm, the Governor of High Down contacted Downview to offer the assistance of his staff. A Helicopter Emergency Medical Service (HEMS) air ambulance crew landed a helicopter on the astroturf pitch at 2.20pm.
112. Sadly, the woman could not be revived and a doctor from HEMS pronounced her dead at 2.29pm. After she died staff gently took hold of her under her arms and moved her body a few inches back inside the cell so that the door could be closed and locked until the police arrived. This was to preserve her dignity and also to protect the other women on the landing from further unnecessary upset.
113. SO B asked one of his officers to sit with the prisoner because she was extremely disturbed after discovering the woman. She remained in a state of extreme shock for a long time and a member of the chaplaincy staff came to sit with her. During the emergency, the Head of Healthcare had temporarily left the cell to quickly check on the prisoner. She advised a DPSM to ask a member of the MHIRT to assess the prisoner. She checked her again. As she was still hyperventilating and seemed to be getting worse, she telephoned High Down, because she knew that there was a general practitioner (GP) still on duty who might be able to come over and treat her. There is no indication as to whether the doctor attended and, when asked, the prisoner remembered little of what happened as she had been sedated.

114. Another prisoner was also very upset because she had been locked back in her cell (next door to the woman's). She then heard the resuscitation attempt through the wall. She explained to the investigators that she had to "scream that I wanted out of the room" and for the staff to move her away from the scene. Both prisoners were put in a cell together for the rest of the afternoon.
115. SO A attended the emergency. As the suicide prevention coordinator, she made sure that case reviews were held for all the other women subject to ACCT monitoring. She also ensured that, because of their distress, the woman's partner and the prisoner who had found her were specifically monitored by staff. Both women were placed on ACCT monitoring following the death. A member of healthcare staff was present while those prisoners closest to the woman were told about her death. The prisoner who found her told the investigators that she did not stop crying all day, and had to be sedated for about 48 hours.
116. The DPSM briefed staff throughout the prison that there had been a death in custody. A short "hot" debrief meeting was held in the chapel for staff involved in the emergency. (The hot debrief meeting allows staff to discuss the incident and check on each other's welfare.) Staff then arranged for each landing of prisoners to be unlocked in turn and be told about the woman's death by the chaplain. An officer and a PEO went from door to door on the wing to speak to the women, make sure they were coping and give them the chance to ask any questions.
117. Staff then managed to return the prison to its normal routine, ensuring that medication was dispensed and that the evening meal was served. However, prisoners on the woman's landing were not allowed to return to their cells until later in the evening once the authorities had dealt with the aftermath of her death. Once all the prisoners had been locked up for the night, a debrief meeting was held by governors in the visits hall for the staff involved in the emergency. The healthcare staff also held their own debrief meeting.
118. An operational debrief meeting took place the following day. The purpose of the meeting was to "review the events of yesterday and see if there were any immediate learning points that could improve our local processes and possibly prevent a recurrence". Attendees comprised the deputy governor, the prison's management team, safer custody manager, IMB member and a representative of the chaplaincy. There were no representatives from healthcare or officers most involved in the incident. The note of the meeting indicated that some of the relevant staff were not on duty that day. It also drew attention to the debriefs held the day before which were primarily to deal with welfare issues and immediate matters concerning the aftermath of the death.
119. A trained family liaison officer (FLO) who normally works at High Down, the prison next door to Downview, was asked to assume the role of FLO and communicate with the woman's relatives. Her recorded next of kin was her landlord. Staff visited his address but no one was at home. However, the prison also had a record of her grandfather's contact details. In the event, the

FLO and a colleague visited her grandfather in Kent in the late afternoon to break the news of her death. He explained that he had not been in touch with her mother for several years.

120. Staff tried the telephone number the woman had provided for her mother but got no response. The FLO managed to speak to her uncle and then her sister later that day. That evening, another member of staff spoke with her brother, who confirmed he would inform his mother.
121. The FLO telephoned the woman's mother to inform her of her daughter's death and that the prison would contribute towards the cost of the funeral. Her family were also able to attend a memorial service held inside Downview, after which they collected her property.
122. A few days after the woman died, staff searched her partner's cell for a blade, prompted by previous security incident reports that she had threatened the woman. However, they found nothing.
123. The care team manager led a critical incident debrief on 15 April. This meeting is intended for staff to reflect on the emergency, consider what lessons might be learned and check on the continuing welfare of the staff involved. The meeting focussed mainly on staff welfare issues.

ISSUES

Context

124. Discussion of events at Downview in 2011 must acknowledge the very public difficulties the prison was experiencing at the time. While there is no evidence to suggest that the woman was directly affected by these events, these were the circumstances staff and prisoners were experiencing at the time, and they bear some brief outline.
125. At the time the woman died, the conduct of some staff at Downview was under public scrutiny. In early 2010, five members of staff were suspended after they were suspected of engaging in sexual activity with women prisoners. Three men were eventually due to stand trial in the summer of 2011. However, one member of staff took his own life before his trial. Another member of staff was subsequently convicted and imprisoned. The jury failed to reach a verdict on the charges against the third man.
126. When the assistant Ombudsman first visited the prison at the beginning of the investigation, she was told that staff morale was low and that staff-prisoner relations had inevitably suffered to some extent in the wake of these revelations. Male officers had taken to patrolling in pairs to prevent any further allegations of impropriety. Staff shortages because of suspension and work-related stress absences had impacted on the regime, reducing the effectiveness of the personal officer scheme.
127. During interviews with staff, the investigators discussed how the prison was coping at such a difficult time. SO B said that Downview was making progress, that the culture was changing and that things were improving. He said that standards had been allowed to decline, but that the new management team were beginning to improve the way the prison was run.
128. When another SO was interviewed in July 2011, she said that staffing levels were “awful” and “really short”. She explained that morale had been affected by the trial of other colleagues. She commented, “...there were a good few months where it just felt as if that’s all we were doing, we were just chasing our tails...” However, she also stressed that the professional relationship between prisoners and officers was “really good”.
129. The governor responsible for the safer custody department commented that it was a difficult time. The management team was changing, and four of the governors were on their second to last day when the woman died. They were just about to have a POA strike ballot. She did not believe this would have had any specific impact on the woman, other than it was a generally unsettled time for everyone.

Clinical care

130. While at Downview, the woman was prescribed two different types of medication to control her epileptic fits. She was also provided with an inhaler

for her asthma. She was prescribed two antidepressants, mirtazapine and then fluoxetine. Finally, she was also given quetiapine, a mood stabiliser used to prevent excessive high and low moods.

131. One of the doctors at Downview told the investigators that quetiapine is not commonly prescribed in the community and is an indication of quite significant mental health problems. He told the investigators that this drug was prescribed for the woman's personality disorder. He commented that the medication that she was given was entirely consistent with her established diagnoses and mental health history. She had previously been diagnosed as "borderline schizophrenic".
132. There were some suggestions that the woman had previously been diagnosed with an inoperable brain tumour. There was no evidence of this on her medical record, including in a letter from the hospital where she had apparently undergone tests. She told the doctor on 3 March, that a scan some years earlier at Chertsey had shown a shadow on her brain. As there was no reference to a tumour, the doctor faxed the hospital on 3 March, requesting her records. At the time of her death, no response was noted in the record.
133. A clinical reviewer completed a review of the clinical care that the woman received at Downview. She concludes that the standard of healthcare she received "was equitable with that available within the wider community". In other words, she believes she would have received similar treatment if she had reported the same conditions to her community GP.

Mental health support

134. The pre-sentence report recommended that the woman receive counselling in prison. The community psychiatric nurse built a strong therapeutic relationship with her and we commend the good support he provided as her mental health nurse. He had very regular contact with her and seems to have held meaningful and constructive discussions with her. He kept detailed records of their meetings and documented his decision-making. While this is the kind of practice one should expect, in our experience this is one of the better examples of consistent ongoing contact with a prisoner.

Detoxification and withdrawal

135. The woman was a long-term heroin user. She completed a detoxification programme after she arrived at Downview. She withdrew firstly using methadone, and then Subutex, two different heroin substitutes. Her withdrawal seems to have been managed appropriately. She was checked regularly by a nurse from the IDTS team. The change from methadone to Subutex was managed effectively and she completed the programme on 22 December. However, within two months she had relapsed and told the nurse that she was misusing Subutex that she had illicitly obtained from other women on the wing. Regrettably, illicit trade in medication is common in prison. She herself was caught trying to conceal her Subutex tablets.

136. After the woman moved to Downview, the recording of her methadone dose in the clinical record was confusing. Different members of staff refer to different amounts of methadone in successive entries. They also confuse milligrams (mg) and millilitres (ml). This is an important distinction and the confusion is not helpful to other colleagues consulting the clinical record. We make the following recommendation:

The Head of Healthcare should ensure that staff accurately record the level of controlled drugs issued.

The woman's relationships and possible bullying

137. At the time of the last full inspection of Downview in 2008, 24% of the women prisoners surveyed said they were gay or bisexual. During her time at Downview, the woman was involved in relationships with three prisoners. SO B described the policing of relationships as a "very, very grey area" in a women's prison. It is difficult for prison staff to determine whether both are willing parties in a relationship, or whether one of the women might be being pressured into sexual relations. Staff face the dilemma of whether to split the women up by moving them to different wings. However, this can cause distress and even prompt self-harm. The woman's relationships with other women in Downview were complex. Her relationships with her former partner and current partner seem to have been especially relevant.
138. The woman's personal officer told the investigators that the woman and her former partner had made it "quite obvious" to everyone that they were together. The officer regarded the prisoner as the woman's partner. The woman planned to move in with her after she was released. Her former partner's murder naturally caused her some distress.
139. Another prisoner thought that the woman had taken her own life because she blamed herself for her former partner's death. The former partner had apparently previously smuggled drugs into prison for her. The prisoner believed that she had felt guilty, because she was under the impression that her former partner had been buying drugs for her when she was killed.
140. The current partner was the woman's co-defendant in the offence of armed robbery, for which the woman was convicted in August 2010. A SO indicated that the woman had not wanted her co-defendant to move to C wing after she arrived at Downview. However, she did move to the wing, and on 11 March, staff found the two women together in her cell.
141. The SO told the investigators that their relationship had seemed to be consensual, because the woman chose to associate with the co-defendant in the prison grounds and would visit her landing. The SO recalled that the two women were always together. She did not think that the circumstances of their relationship were completely clear and it was difficult to tell whether she was fully consenting. The SO believed that the woman was not someone who

could easily be bullied or coerced. She felt that she was able to stand her own ground.

142. However, a prisoner told the investigators that the woman was scared of the co-defendant finding out that she was planning to live with someone else after she was released. The prisoner recalled that she had not wanted to continue her relationship with the co-defendant, but that the co-defendant had carried a blade with her and had threatened to harm her. She had told a facilitator on the TSP that her co-defendant had threatened to cut her with a blade. The prisoner described her as “crying out for help”.
143. The prisoner told the investigators that circumstances at Downview had improved since, and because of, the woman’s death. She explained that potential and actual bullying was taken more seriously and the behaviour of more prisoners was monitored.
144. The co-defendant and the woman had apparently begun their relationship during a previous custodial sentence. They then committed the offence of armed robbery together.
145. On 11 March 2011, staff received information about threats the co-defendant had apparently made to the woman. These allegations were detailed in Security Incident Reports (SIRs). There was a report of the co-defendant possibly using a blade to threaten her. It is not clear what, if anything, was done with this information. Staff knew that they were involved in a sexual relationship, but the true nature of their relationship was ambiguous and potentially involved an element of coercion. Although staff recorded that the wing manager and violence reduction coordinator were to be informed, there is no evidence that a formal bullying investigation or monitoring then took place, or that any thought was given to moving the co-defendant to a different wing. The information that she was carrying a ‘blade’ was not acted on by a search of her cell until after the woman’s death.
146. Some months previously, in November 2010, the woman had already told the psychiatric nurse from the MHIRT that she was being bullied. However, the matter does not seem to have been referred to the violence reduction coordinator at that time. We note that a main recommendation from the 2008 inspection about the need to improve the procedures for reporting, investigating and monitoring bullying behaviour and the particular form it took among women, had not been achieved by the time of the September 2011 inspection. We make the following recommendation:

The Governor should ensure that staff understand that all information about bullying, threats and potential violence is fully considered and acted on through a robust and responsive violence reduction policy, that reflects the tensions in a women’s prison.

Assessment, Care in Custody and Teamwork (ACCT) self-harm monitoring

147. The investigators spoke to the Head of Safer Custody about the use of the ACCT self-harm monitoring document at Downview. She commented:

“... my gut feeling would be that people don't necessarily understand ACCT brilliantly...the majority of staff who work in the prison ... I think it's a very complicated document to get right... all it does is become an observation document rather than a document that is meant as a support in itself to reduce risk and change the behaviour ... I think a lot of staff are very cynical and feel it is just about if I check someone four times an hour they're not dead on my watch... three conversations daily, well they're meaningless if it's just 'read the paper today'...”

148. As regards the woman's ACCT monitoring, the clinical reviewer writes:

“Although the risk of a suicidal act had been recognised because of her receiving bad news, and she was placed on the ACCT process and document, there was no acute warning sign that any act of self harm was imminent prior to the incident.”

149. Although the woman had some history of harming herself, she had not tried to do so while she was at Downview before her death. It was her former partner's murder that prompted staff to begin ACCT self-harm monitoring. Although some of the other prisoners later came forward to suggest that she had given them cause for concern, saying she wanted to be with her former partner, this information does not, for the most part, seem to have been relayed to staff before she died. A prisoner did express concerns to an officer on the day she died. A SO told the investigators that she seemed “absolutely fine” in the days leading up to her death. He said that none of the other prisoners had spoken to him about any concerns that she was not coping.
150. The most recent HMIP report about Downview commented that Caremaps were not always completed or reviewed. In the woman's case, the Caremaps were incomplete. The goals identified were too generic, repetitive and not specific enough to her needs.
151. Senior officers carried out daily management checks on the woman's ACCT document. These were clearly recorded and sometimes raised very pertinent questions about the level of observations. It is rare to see such well documented and consistent management checks, but it is unfortunate that none commented on the quality of the Caremaps.

The Governor should ensure that goals set in Caremaps are specific, timely and relevant to each woman's needs. They should be actioned as planned, followed up at each review and subject to rigorous management checks to help ensure effective continuity of care.

First ACCT case review

152. When the ACCT document was opened, staff were initially asked to check the woman “twice hourly”. After the first ACCT case review, the frequency of checks was slightly amended. Staff were required to check her twice an hour during the patrol state and also record conversations with her. However, this decision was not clearly recorded at the case review and the switch to a different frequency of observations was not marked with the time and date on the front cover on the ACCT document as it is supposed to be. There was also no indication as to how many conversations were supposed to be recorded each day. (Often, for example, there would need to be a meaningful conversation in the morning, afternoon and evening.) We make the following recommendation:

The Governor should ensure that all case managers clearly record changes to the frequency of ACCT monitoring in the case review and on the front cover of the document. The case manager’s reasoning must be included in the case review notes. A change in frequency must be marked with the date and time on the front cover.

Frequency of observations when the woman died

153. SO A questioned SO B’s decision to reduce the frequency of ACCT observations. Following a second ACCT review on 24 March, SO B instructed staff to check the woman at least once an hour overnight. However, officers were not required to perform any formal ACCT checks during the daytime or record any conversations with her.
154. SO A, who was the Suicide Prevention Coordinator at the time of the woman’s death, carried out a management check on the ACCT document on 29 March, and subsequently emailed SO B suggesting that he might want to ask his staff to check her during the day. She was unclear what measures were in place to monitor her when she was locked up during the daytime. She suggested three quality conversations: one in the morning, one in the afternoon and another in the evening before lock-up.
155. We think that this was a sensible suggestion. If a prisoner is regarded as sufficiently vulnerable to warrant self-harm monitoring, then the ACCT document should include some meaningful interaction with staff each day. This helps the case manager conducting the next ACCT review to gauge an accurate picture of the prisoner’s mood and behaviour throughout the previous week. Checks during the night do not normally involve conversations with the prisoner unless they are awake or have a problem. Often the officer only checks for movement and records this information. Conversations during the day are, therefore, the best way to monitor a prisoner’s mood.
156. The two senior officers exchanged emails and SO B replied indicating that he would take SO A’s advice into account. He explained to the investigators that

he had intended to review the number of daytime checks when he led the next ACCT review. The email exchange concluded at lunchtime just an hour or so before the woman was found hanging in her cell.

157. SO B told the investigators that he accepted responsibility for the level of observations at the time the woman died. They were set at the ACCT review meeting that he had chaired. He said that he appreciated SO A's guidance because safer custody was her area of expertise. SO A told the investigators that she was satisfied that SO B planned to take her advice and implement ACCT checks during the daytime.
158. We do not think that additional ACCT checks in the daytime would have stopped the woman from taking her own life. Even if a review had taken place before she died, it is likely that officers would have been asked to speak to her once in the morning, afternoon and evening. As it was, the prisoner's concerns prompted two different officers to speak to and check her at the start of the lunchtime lock up, although too much reliance seems to have been placed on her own view that she did not want to have frequent checks. Nevertheless, on the day of her death, effectively she did receive daytime ACCT checks and the checks were recorded in the ACCT document. It is unlikely, on the evidence available, that a review would have implemented frequent day time checks. It is of note that the mental health nurse saw her for a mental health review just hours before her death and saw no indication of anything that caused him to be concerned. However, we consider that SO A's advice was sound and we make the following recommendation:

The Governor should ensure that checks on any prisoner subject to ACCT monitoring are not restricted to night time only. Case managers should require some level of interaction with the prisoner during the day, particularly when women are locked in their cells alone, and these conversations should be recorded in the ACCT document.

Overnight ACCT checks

159. The recording of the overnight hourly ACCT checks was not completed to an acceptable standard. The woman was supposed to be checked at least once an hour. However, these checks are supposed to be performed at random intervals so that the prisoner cannot predict the next visit from an officer. If the gaps between checks become too predictable, there is a danger that the prisoner plans to harm herself during that time. Staff at Downview ticked pre-printed boxes in her ACCT document at fixed times such as 3.00am, 4.00am, 5.00am. On 22 March, the senior officer performing the ACCT management check recorded that the night time checks on her were "too predictable".

The Governor should ensure that staff perform ACCT checks at random intervals within the designated frequency and record these on the ACCT document itself.

Timing of the ACCT review on 30 March

160. SO B had scheduled the woman's next ACCT review for 10.30am on 30 March. However, he told the investigators that due to his workload in the morning, he had asked her if they could hold the review that afternoon instead and that she had agreed. We note that this was poor planning as if the SO had organised the review properly he would have discovered that she had an appointment with the psychiatric nurse at 10.30 on 30 March. Nor is there any indication that the SO advised other possible attendees at the ACCT review of the change of time.
161. It is only with the benefit of hindsight that this delay of a few hours assumes significance. We are satisfied that SO B still intended to hold the review on the day originally scheduled. The Head of Safer Custody thought that it would have been helpful if SO B had written in the ACCT document that the review was due to take place in the afternoon. The last minute change of time, and the fact that the woman had an appointment at the time that the SO had intended to hold the review, does not suggest the review was well planned or organised to allow a full range of multi-disciplinary attendance. We make the following recommendation:

The Governor should ensure that staff clearly record all decisions about ACCT monitoring and reviews in the ACCT document and that case managers plan, and take account of, the availability of all attendees when scheduling reviews.

A prisoner's concerns on day of the incident

162. A prisoner expressed concern about the woman to Officer A before she was locked up at lunchtime. She thought that her mood was low. The officer checked her but did not amend the ACCT observations. However, he did make an entry in the ACCT document. The prisoner told the investigators that she thought the officer dismissed her concerns to some extent, and did not pay attention to what she told him. She did not think that the staff had been monitoring the woman "properly". She thought that this problem might have arisen because the officer did not normally work on their landing.
163. We think it was appropriate that Officer A checked the woman, spoke to her and recorded their conversation in the ACCT document. He asked her if she thought that she needed more ACCT checks and she said that she did not. We also think it was sensible and reasonable for the officer to relate the prisoner's concerns to Officer B and ask him to check the woman during the lunchtime lock-up. Officer B performed another check, although only ten minutes after Officer A's. Officer B explained to the investigators that, regardless of the frequency of checks (in the woman's case only overnight), he checks all prisoners subject to ACCT monitoring when he assumes responsibility for a landing after a lunchtime handover. We acknowledge that Officer A was responsive to the prisoner's concerns but, we consider that there was too much reliance on the woman's response that she was all right and did not wish to have additional checks. It is disappointing that no

consideration appears to have been given to other ways of providing support to her during the lunchtime period, or that she was not checked again during the lunchtime period. Nevertheless, we accept that it would have been difficult to foresee that she intended serious self-harm at that stage.

Significant anniversary

164. Prison staff made a reference in the ongoing ACCT record to a “painful anniversary” for the woman on 15 April. Anniversaries can be a trigger for self-harm or suicide, but it is not clear from prison documentation what this comment refers to. Her mother told the investigator that the anniversary of her father’s suicide was around the time of her death. This might have been the painful anniversary referred to. It was also suggested that this could have referred to it being a month since her former partner’s death. As the anniversary was sufficiently significant to record in the ACCT document, there should have been more clarity about the nature of the anniversary, the possible impact and staff action to be taken. Accordingly, we make the following recommendation:

The Governor should ensure that staff record important details of significant anniversaries that are likely to lead to a prisoner considering self-harm, as well as the action to be taken by staff to provide support.

Unlocking procedures

165. On the day of the incident Officer C unlocked the prisoners on the woman’s landing after lunch. She accepted she did not look into her cell through the observation hatch before turning the key and moving onto the next door. As a consequence, she did not see her hanging, and it was a prisoner who was the first to open the cell door, after she herself was unlocked.
166. For their own safety, officers are supposed to look at and make contact with a prisoner through the observation hatch before opening a locked cell door. This is a precaution, in case the prisoner is waiting to assault the officer. It also supposed to be a check on the prisoner’s wellbeing and is especially advisable for prisoners, such as the woman, who are subject to ACCT monitoring. Staff had been told before lunch to keep an eye on her and by that time she had been on her own in her cell for an hour.
167. Unfortunately, because she herself did not find the woman, Officer C lost the opportunity for a degree of control over subsequent events. The women were all unlocked and on their way to their work placements. The prisoner understandably was extremely shocked when she opened the cell door and her distress inevitably spread to the other prisoners. The situation became emotionally charged.
168. Officer C explained to the investigators that her approach to unlocking prisoners without checking them first through the observation hatch was standard among her colleagues at Downview. When interviewed, she said that she would normally check the welfare of prisoners with open ACCT

documents after a period of confinement in their cells. However, we note she did not do so on this occasion.

169. SO B was in charge of C wing on the day the woman died. He told the investigators that staff can tend to become “complacent” and “standards do slip”. He explained that time constraints had resulted in some officers not unlocking cells in the way they were shown during training, but agreed that staff should open the observation hatch to check the prisoner and obtain a response to make sure that it is safe to unlock the cell. He said that unlocking can be a time consuming process, and that therefore the task tends not to be carried out properly every time. He suggested that the management team at Downview had been responsible for this lax approach, rather than individual officers.

170. The Head of Safer Custody said that that staff had developed “a bad habit”. She commented that officers should announce their presence before beginning an unlock (particularly if they were male, for the sake of the women’s decency) and then:

“People should be knocking, opening the flap...opening the door and shooting the bolt. I do. I never go into a cell without knowing what I’m going into.”

171. The Head added, “...it’s like bread and butter, opening and closing doors. If [officers] can’t get that right then they need to get another job”.

172. The investigators suggested that officers thought that they did not have enough time to perform all the necessary steps to unlock each prisoner. The Head responded:

“No, that’s no defence. What does it take you, ten seconds more to knock on the door and open the flap per cell door? Most of our landings you’re talking about it might take you three minutes more – that’s rubbish.

“...I think there’s a culture of ‘we don’t have time to do anything’... it’s a convenient excuse... an extra three minutes is what we’re talking about to unlock a landing decently.

“The resistance I think, in my opinion, is coming from staff feeling they’ve been asked to do another thing rather than being asked to do their job.”

173. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Emergency code system

174. There are three emergency response codes used at Downview:
- Code 1 – the prisoner has no pulse and is not breathing, this is the most serious requiring immediate attendance
 - Code 2 – the prisoner is fitting or has chest pain
 - Code 3 – other, less urgent incidents
175. Officer C told the investigators that when she first responded to the prisoner's screams, she used her radio to give her location and request healthcare assistance at the cell. She could not remember if she used a code. There is no record of her request in the control room log.
176. After he had removed the sheet from the woman's neck, Officer A said that he radioed the control room staff to confirm that they correctly understood the seriousness of the emergency. Again, there is no record of his message in the control room log.
177. SO B made two requests to the control room which were logged. The first did not give the nature of the emergency and in the second communication he used the wrong code, 'Code 3' instead of 'Code 1'. He explained that he had not been working at Downview for long, had received no training in the code system and had been used to an alternative code red and code blue system at High Down, the prison next door where he had previously worked.
178. The confusion on the wing was also reflected in the control room. Although the use of the code system had been incorrect, some staff sensed from the tone of the officer's voice and the noises coming from the wing that something was very wrong. However, some staff attending the incident did not know which cell to go to, or what the nature of the emergency was. The Head of Healthcare recalled that the "warbler" which sounded across the radio network was unusual, and she knew immediately that something was wrong. However, the nursing staff then heard a "code 3" announced, so they were confused about the seriousness of the emergency. We make the following recommendations:

The Governor should ensure that all staff working with prisoners fully understand the emergency code system.

The Governor should ensure that during emergencies all requests made to the control room are recorded in the control room log.

179. As High Down and Downview are neighbouring prisons. A very small number of staff work at both prisons and staff sometimes transfer between the two. It is therefore a concern that the prisons use different emergency code systems. The National Offender Management Service has been examining the feasibility of a unified emergency code system for all prisons for some time. In the meantime it would seem sensible for High Down and Downview to use the same system. We make the following recommendation:

The Governor of Downview should agree with the Governor of High Down a common emergency code system.

Management of the incident

180. A number of staff described a chaotic situation on the wing after the woman was found hanging in her cell. This was partly circumstantial, because the women on the landing had just been unlocked. Some had left the wing to go to work, but many others were still there. Had she been discovered five minutes earlier, at the start of unlock, or later when most of the women had left the wing, the situation on the landing would have been very different.
181. Officer C said that the emergency could not have happened at a worse time and a number of women prisoners were screaming. SO A, who attended, said there were too many people on the landing and she believed some staff needed to withdraw so that only those crucial to the resuscitation effort were present. She said there was no clear allocation of tasks to staff so there was some confusion about roles. The PEO gave a similar account and expressed sympathy for SO B, who remained at the cell door to shield the cell from other prisoners and to also direct prisoners either to work or to their cells. At the same time, he was trying to communicate crucial information across the radio network. The Head of Healthcare also described a very confused situation, with no clear oversight.
182. SO B told the investigators that he was forced to make decisions that other people should have been making, such as arranging for officers to collect and escort the paramedics. We make the following recommendation:

The Governor should ensure that there are well understood and practiced contingency arrangements to deal with emergency situations, which set out clear roles and responsibilities for prison and healthcare staff.

The resuscitation effort

183. Officer A told the investigators that it felt like he was performing CPR for a very long time before healthcare staff arrived. He explained that he had previously received first aid training, but that this was no longer up to date. Officer B was also not currently first aid trained when the woman died. He agreed that it seemed to take a long time for the healthcare staff to reach the cell, and that when they did, they seemed “a bit flustered and unorganised”. SO B was not first aid trained. The PEO did have first aid training because it is obligatory for all staff who work in the gym.
184. Officer C explained that she had no current certificated first aid training, aside from a short session introducing her to CPR. Nonetheless, she felt confident to give breaths during the emergency. She had the foresight to carry a protective mouth guard to help her give breaths safely. Although this is recommended as good practice, officers are frequently ill-prepared to start

CPR. Despite their lack of in-date training, the officers involved made good and appropriate efforts to resuscitate the woman.

185. It is not unusual to find that few officers have up-to-date emergency first aid training, but this is a matter of concern. Although it did not appear to hamper the efforts on this occasion, it can lead to officers feeling out of their depth and unable to provide effective help in an incident when they find an unresponsive prisoner. Although nurses came to the cell relatively quickly, reliance on qualified health care staff, not all of whom themselves have up to date first aid training, can mean that essential minutes are lost. However, there is no indication in this case that there was any undue delay.
186. The clinical reviewer found in her review that healthcare staff used “appropriate equipment” in their attempts to resuscitate the woman once they reached her cell.

The Governor should ensure that there are sufficient up to date emergency first aid trained staff on duty to cover all wings, at all times, to provide a quick and effective response in an emergency.

Requesting an ambulance

187. When the Head of Healthcare and her nursing colleagues arrived at the cell, she instructed the discipline officers at the scene to ask the control room staff to request an emergency ambulance. Already, several minutes had passed since the prisoner discovered the woman. The Head told the investigators that it “felt like ages” until the paramedics arrived on the wing.
188. As the woman was found hanging, the officers who found her should have immediately requested an emergency ambulance and not waited for healthcare staff to attend. This is in line with national Prison Service guidance. In the very unlikely event that a prisoner in her situation does not require an ambulance, such a request can always be cancelled. We make the following recommendation:

The Governor should ensure that all members of staff understand that they should call an emergency ambulance immediately whenever there are grave concerns about the health of a prisoner.

Staff support

189. There were mixed accounts of the support that staff said they received after the woman died. SO B felt that the support he had been offered was “quite poor”. An officer described the support offered as “blasé”. The PEO told the investigators that she was also dissatisfied with the support she received. She said that nobody contacted her personally, but she had received a telephone call providing a support service telephone number. It was only once she asked for help, during a visit to the occupational health nurse for an unrelated problem that she was referred for counselling. The Head of Healthcare said that she was unaware of a formal offer of support to her

nursing staff. We would expect such support to be offered by the PCT, the employer of the healthcare staff. She expressed disappointment that her team had not been involved in the debrief after the woman's death.

190. On the other hand, Officer C said that she was offered good support. She explained that a member of the care team had "kept an eye on her" after she left the cell. After she went home, she told the investigators that the Head of the Care Team telephoned her that evening and told her not to come to work the following day. Officer B also told the investigators that he had spoken to the care team and was happy with the support he had been offered. SO A described the care team's support as "excellent".
191. The Head of Safer Custody similarly disputed that staff were not adequately supported after the woman died. She also praised the care team's efforts and confirmed that all the necessary debrief meetings had taken place. She commented:

"We have a real issue because of other things going on, like the trial... of staff feeling generally fed up and this being not a good excuse but using it to be very anti-management..."

"And I know SO B was very critical [of] the way that we managed it, but I knew personally that I rang him, I know the DPSM rang him, I know a member of the care team rang him ... I also know this was about his third death in custody in a very short period of time, so I know that he was struggling."

192. Although there are different perceptions of the level of support, we are satisfied that the relevant debriefs were held to address staff welfare issues.
193. The operational debrief that took place the following day involved predominantly prison managers, with no representation from officers or healthcare staff involved in the response. It was agreed there should be a review of unlocking procedures to ensure that staff observed prisoners when they unlocked them; a review of the emergency code procedures; and contingency plan contact numbers should be updated. We consider that there should have been better representation of those involved in the incident at the meeting and make the following recommendation:

The Governor should ensure that all staff involved in an emergency are invited to the operational debrief meetings.

Family liaison

194. The family were critical of the way in which the prison's family liaison officer (FLO) dealt with them. They described him as insensitive. When he spoke to the investigators he denied this was the case and said he was very disappointed to hear this.
195. The FLO thought that the woman's family were unhappy with decisions made by the Coroner's office (about viewing her body) and that the prison had not allowed the co-defendant to attend the funeral. He stressed that he liaised with the family throughout the process and provided information including the Coroners telephone number, but was ultimately not responsible for certain decisions.
196. The woman's relatives were told that they would be given the cards and letters from prisoners, which they had seen at the memorial service. However, there was a delay in these being sent to them. The woman's mother told the investigator during the home visit on 24 May that she had still not received the cards and letters. The FLO explained that he was not able to oversee the packaging and dispatch of the cards and letters because he did not work at Downview and was based at High Down. He did stress that the family were given her property before they left the prison on the day of the memorial service. We think that the use of a FLO from another prison probably added to an already complicated situation involving a number of family members.
197. It was not at all easy for the FLO to contact the woman's mother. The investigators suggested to him that he might have turned to the police for help. He explained that he would consider taking this step in future, but had not done so on this occasion because he had visited the woman's grandfather in person. We sympathise with the problems he encountered because several family members had no current contact details for the mother. However, another member of staff was able to speak to the woman's brother that evening and he said he would pass the news to his mother. In cases of difficulty in tracing families the police can often be of considerable assistance and so we make the following recommendation:

The Governor should ensure that the help of the police is sought when there are difficulties contacting family members following a death in custody.

CONCLUSION

198. Downview was a troubled prison at the time the woman died and, although not apparently directly related to her death, some of what staff told the investigators reflected this.
199. At the time of her death, the woman was subject to ACCT monitoring, but observations were required only at night. After a prisoner indicated her concern to Officer A on the lunch time that she died, he went to check on her. He passed the concerns on to another officer who also went to see her. Both officers were satisfied she was coping. It is unfortunate that the officer did not consider alternative ways of protecting her, such as suggesting the prisoner sit with her in her cell or getting a Listener. It seems unlikely that a prisoner intent on killing herself would indicate to an officer that she wanted more checks and too much reliance was placed on what she said. As the Head of Safer Custody commented, there is a danger that the ACCT process is seen too much as an observation document rather than a support in itself. Nevertheless, we believe that staff took what appeared to be appropriate action at the time, even if with hindsight, we might wish that more had been done.
200. It is unlikely that, had an ACCT review had taken place in the morning as planned, that the level of observations would have been raised significantly. The woman had had a mental health review that morning and the nurse had no concerns about her state of mind. She had not tried to take her own life before at Downview. She was subject to ACCT monitoring because of the death of her partner, but had not shown any previous signs of trying to harm herself. Although a more active approach to supporting her through her grief would have been preferable, on balance, we consider that the level of checks that day were reasonable in the circumstances and prison staff could not have been expected to foresee her actions.
201. The response to finding the woman hanging in her cell was not well coordinated. The investigation has identified a need for well rehearsed contingency arrangements for an emergency and a need for a clear chain of command in such circumstances.

RECOMMENDATIONS

The following recommendations were made in our draft report. Responses to the recommendations received from the National Offender Management Service (NOMS) are included in italics following each recommendation.

For the Governor of Downview:

1. The Governor should ensure that staff understand that all information about bullying, threats and potential violence is fully considered and acted on through a robust and responsive violence reduction policy, that reflects the tensions in a women's prison.

Response from NOMS: recommendation accepted

A violence reduction planning day was held in May 2012 and as a result, a new policy document has been developed which focuses on tackling antisocial behaviour and addresses the complexities of managing such behaviours in a female establishment. Women's Team have been consulted in the development of the policy. The policy will be launched at a 'spotlight' session in September 2012. The role of the safer prisons co-ordinator has also been broadened to include responsibility for violence reduction as well as preventing self harm and suicide.

Target for completion: September 2012

2. The Governor should ensure that goals set in Caremaps are specific, timely and relevant to each woman's needs. They should be actioned as planned, followed up at each review and subject to rigorous management checks to help ensure effective continuity of care.

Response from NOMS: recommendation accepted

Training is being delivered which focuses on ACCT. This includes a section on care maps. The remainder will be trained during the next six months.

Target for completion: March 2013

The Head of Safer Custody has also completed a qualitative review on ACCTs during the last three months and actions identified will be incorporated into the safer prisons action plan.

Target for completion: October 2012

3. The Governor should ensure that all case managers clearly record changes to the frequency of ACCT monitoring in the case review and on the front cover of the document. The case manager's reasoning must be included in the case review notes. A change in frequency must be marked with the date and time on the front cover.

Response from NOMS: recommendation accepted

This has already been addressed by the introduction of a new management check sheet. The new format of the ACCT document also makes the recording of monitoring clearer.

Target for completion: action completed

4. The Governor should ensure that checks on any prisoner subject to ACCT monitoring are not restricted to night time only. Case managers should

require some level of interaction with the prisoner during the day, particularly when women are locked in their cells alone, and these conversations should be recorded in the ACCT document.

Response from NOMS: recommendation accepted

This has already been implemented and is monitored by the Head of Safer Custody and Safer Prisons Manager.

Target for completion: action completed

5. The Governor should ensure that staff perform ACCT checks at random intervals within the designated frequency and record these on the ACCT document itself.

Response from NOMS: recommendation accepted

This has been reinforced at the safer prisons meeting and via wing briefings. However, the Head of Safer Custody will further emphasise this in a Governor's Order.

Target for completion: September 2012

6. The Governor should ensure that staff clearly record all decisions about ACCT monitoring and reviews in the ACCT document, and that case managers plan and take account of the availability of all attendees when scheduling reviews.

Response from NOMS: recommendation accepted

This has been incorporated into the learning tool as described above. Progress has also be assessed as part of the review of ACCTs.

Target for completion: action completed

7. The Governor should ensure that staff record important details of significant anniversaries that are likely to lead to a prisoner considering self-harm, as well as the action to be taken by staff to support the woman.

Response from NOMS: recommendation accepted

This has been incorporated into the training tool referred to in point 2. The qualitative review of ACCTs will check that such details are being recorded.

Target for completion: October 2012

8. The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner, and that there are no immediate issues that need attention.

Response from NOMS: recommendation accepted

This was identified following the operational debrief and we changed the unlocking procedures shortly afterwards. Staff now check all rooms at the time they unlock for movement to activities.

Target for completion: action completed

9. The Governor should ensure that all staff working with prisoners fully understand the emergency code system.

Response from NOMS: recommendation accepted

The Head of Security will issue a Governor's Order explaining the code system. This information will also be displayed in the control room, on notice boards and on the Intranet.

Target for completion: September 2012

10. The Governor should ensure that during emergencies all requests made to the control room are recorded in the control room log.

Response from NOMS: recommendation accepted

The Head of Security will advise all staff who work in the control room via a Governor's Order that such requests must be recorded in the log.

Target for completion: August 2012

11. The Governor should ensure that there are well understood, and practiced, contingency arrangements to deal with emergency situations, which set out clear roles and responsibilities for prison and healthcare staff.

Response from NOMS: recommendation accepted

The Head of Security will organise a contingency exercise to test our arrangements and put in place any remedial action as a result.

Target for completion: October 2012

12. The Governor should ensure that there are sufficient up to date emergency first aid trained staff on duty to cover all wings, at all times, to provide a quick and effective response in an emergency.

Response from NOMS: recommendation accepted

The HR Business Partner will identify staff to be trained in emergency first aid and ensure this is delivered in our training plan for 2012-13.

Target for completion: March 2013

13. The Governor should ensure that all members of staff understand that they should call an emergency ambulance immediately whenever there are grave concerns about the health of a woman prisoner.

Response from NOMS: recommendation accepted

The Head of Security will issue a Governor's Order informing staff of the need to request an ambulance in such instances via the control room.

Target for completion: August 2012

14. The Governor should ensure that all staff involved in an emergency are invited to the operational debrief meetings.

Response from NOMS: recommendation accepted

The Governor will ensure that all relevant staff are invited to debrief meetings.

Target for completion: action completed

15. The Governor should ensure that the help of the police is sought when there are difficulties contacting family members following a death in custody.

Response from NOMS: recommendation accepted

The Governor has advised senior managers of the need to seek the help of the police in contacting family members following a death in custody.

Target for completion: action completed

16. The Governor of Downview should agree with the Governor of High Down a common emergency code system.

Response from NOMS: recommendation accepted

In reality, there are very few staff who work in both prisons and so a common emergency code system is not necessarily required. However the Head of Security will explore whether a shared code system will be of benefit to both prisons and implement if so.

Updated from OSRR

A new PSI is currently being drafted which will require all prisons to adhere to a nationally prescribed code system.

Target for completion: November 2012

For the Head of Healthcare at Downview:

17. The Head of Healthcare should ensure that staff accurately record the level of controlled drugs issued.

Response from NOMS: recommendation accepted

All prescribing is now fully electronic, which ensures accurate records.

Target for completion: action completed