

**Prisons &
Probation**

Ombudsman
Independent Investigations

Learning lessons bulletin

Fatal incidents investigations | Issue 13

Self-inflicted deaths among female prisoners

Foreword

This bulletin was prompted by the recent dramatic and depressing rise in self-inflicted deaths of women in prison. It looks at 19 investigations between 2013 and 2016 of instances where women took their own lives. This small sample cannot explain this apparently rising toll of despair, but the bulletin does identify a number of important areas of learning. This learning focuses on improving suicide and self-harm prevention procedures, better assessment and management of risk, addressing mental health issues, combating bullying and ensuring timely emergency responses.

I have to add I find it disheartening that many of the lessons we identify repeat those in previous publications from my office. This suggests it is not a lack of knowledge that is the issue, but a lack of concerted and

sustained action. While we often identify examples of excellent and compassionate care by individual staff, and also recognise that prisons have been under enormous strain in recent years, there can be no excuse for not implementing essential safety arrangements that could ensure vulnerable women in prison are better protected.

It is to be hoped that delivering safer outcomes for women (and men) in prison will be at the heart of the Government's new prison reform agenda, and that this bulletin can assist with this and help reverse the unacceptable and tragic rise in self-inflicted deaths.

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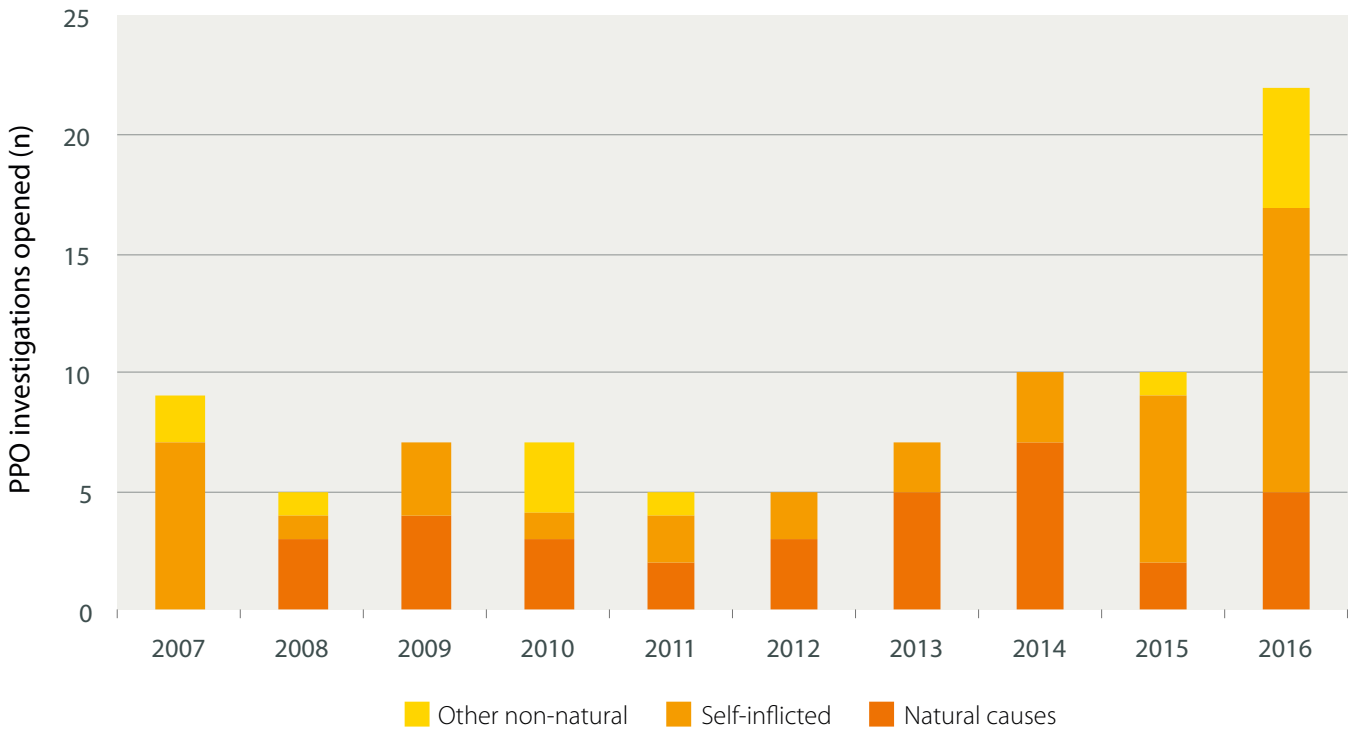


Introduction

This bulletin has been prompted by the sudden increase in the number of deaths of female prisoners. In 2015, for the first time since 2007, women had a higher number of self-inflicted deaths per 1,000 prisoners¹ than men. Overall, deaths of female prisoners more than doubled in 2016 compared to the previous calendar year, and this rise shows little sign of abating.

Figure 1 shows the rise in deaths of female prisoners in 2016 and demonstrates the increase in self-inflicted and other non-natural deaths which started in the previous year.

Figure 1: deaths among female prisoners 2007 – 2016 subject to investigation by the Prisons and Probation Ombudsman, by classification



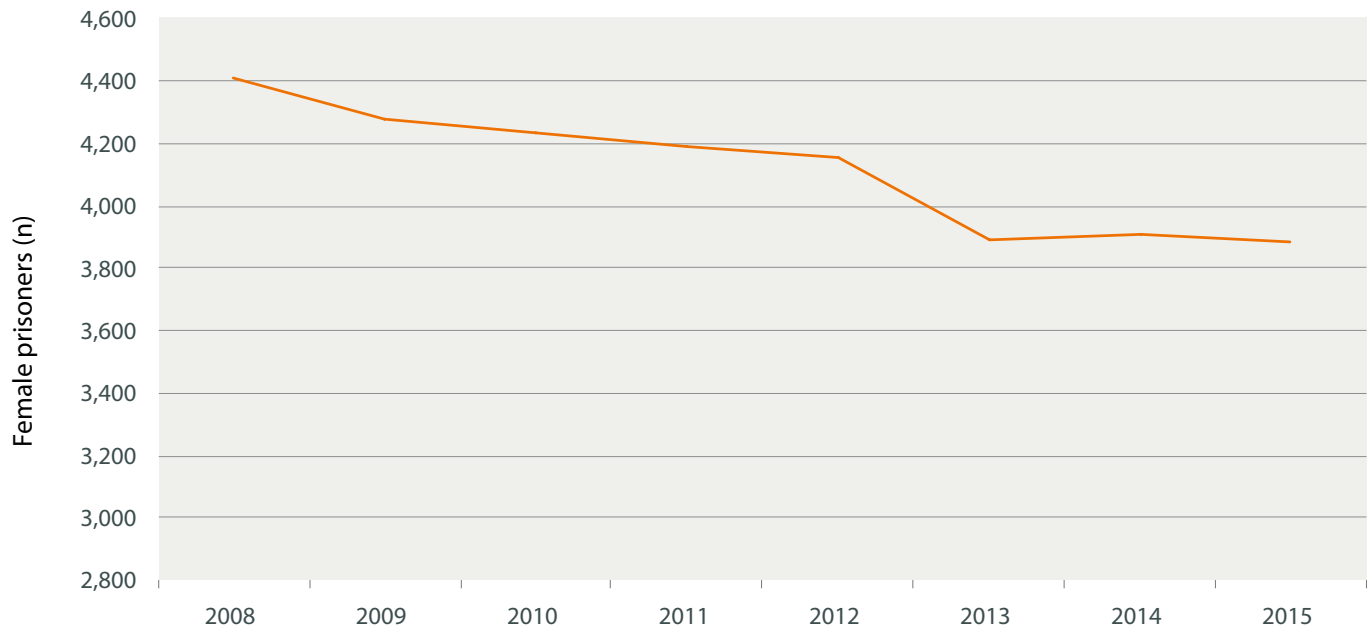
This bulletin draws on a review of recent fatal incident investigations. These were nineteen fatal incident investigations into self-inflicted deaths of female prisoners who died over the period 2013 to 2016 (each completed case of that type from this time period). It seeks to highlight common issues and lessons in order to contribute to improved safety in prisons.

Background: female prisoners

Ministry of Justice data show that there are 3,869 female prisoners compared to 80,988 in the male estate,² representing 5% of the total prison population. As shown in Figure 2, the number of women in prison has reduced gradually since 2008, while the male prison population has continued to rise. Female prisoners are currently

held in 12 establishments,³ two of which are privately operated. All are classified as resettlement prisons, generally providing a range of support and supervision services aimed at rehabilitating prisoners and reducing reoffending. The services available include detoxification units, Psychologically Informed Planned Environments and mother and baby units.

Figure 2: female prison population 2008 to 2015⁴



The Prison Service Order (PSO) on women prisoners⁵ points to their often vulnerable nature, stating “staff in women’s prisons...are likely to be dealing...with more stressful situations than most staff in male prisons.... they cope with many prisoners who are highly dependent on staff for emotional support and will be managing prisoners with many vulnerabilities”.

This suggestion of vulnerability in the PSO is reflected in evidence on issues such as mental illness and self-harm in prison and the community. For example, Ministry of Justice research⁶ has shown female prisoners report poorer mental health than males across a range of disorders, and that almost one in two reported having attempted suicide in the past. This was more than twice the male rate,⁷ and more than six times the rate of women in the community, as reported in other research.⁸

While female prisoners represent only 5% of the prison population, the latest available data show that they account for 23% of all recorded incidents of self-harm.⁹ Although self-harm among male prisoners has been increasing in recent years, the number of females known to self-harm per 1,000 prisoners is still around three times the male figure. The number of recorded incidents per 1,000 prisoners is more than six times as many,¹⁰ indicative of the prevalence of frequent self-harmers in the female estate.

Following calls for a public inquiry after the deaths of six women at Styal prison in Cheshire over thirteen months in 2002 and 2003, Baroness Corston was appointed in 2006 to conduct a review into the experiences of vulnerable women in the criminal justice system. Her inquiry became a significant milestone in the history of female incarceration in the UK.

The Corston report¹¹ was critical of the high numbers of women in prison serving short sentences for non-violent offences, and argued there were too many women in prison on remand, many of whom did not go on to receive a custodial sentence, or for breach of licence conditions. She argued that prisons, having essentially been designed for men, were disproportionately harsh on women and that short sentences for minor offences not only caused chaos within families, but were ineffective in addressing criminality as they did not address the underlying domestic, personal and socio-economic disadvantages women experienced. Corston argued for a complete rethink of the criminal justice system's approach to women, and argued that equality between men and women was not achieved through equal treatment, but through ensuring an equal outcome.

While the Government accepted most of Corston's 43 recommendations, the sweeping whole-system reform envisaged has yet to be delivered. In 2013, a Justice Select Committee inquiry report¹² welcomed a number of developments since Corston, but concluded that the female prison population had not fallen sufficiently fast, there had been limited growth in local services to tackle the underlying causes of female reoffending and that the gender equality duty¹³ had not consistently informed government policy. While there had been discussion of a whole-system approach to female offending, according to the inquiry report, there had been "little to signal a radical shift in thinking about what this means".

More recently, the Prison Safety and Reform white paper¹⁴ set out Government plans to introduce five new community prisons for women, attached to existing prisons but operating independently and with strong links to local community services. However, it remains to be seen how effective these will be.

In the years that followed the Corston inquiry, self-inflicted deaths among female prisoners ranged between one and three per year. In 2015, numbers began to increase, with seven self-inflicted deaths compared to three in 2014.¹⁵ The number of such deaths continued to rise in 2016, reaching 12 by the year end.

Context to this bulletin, definitions and methodology

This is the first Prisons and Probation Ombudsman (PPO) publication to focus specifically on female prisoners, although previous publications have mentioned them where appropriate. By the close of 2016, the PPO had completed 2,421 investigations into deaths in prisons since the office started investigating fatal incidents in 2004. Of these, 101 (4%) were deaths of female prisoners, a slightly lower proportion than the 5-6% of the total prison population they have comprised during that time.¹⁶ A further 20 investigations into the deaths of female prisoners were ongoing at the end of December 2016.

Female deaths in prison are most commonly categorised as self-inflicted, in contrast to the male estate, where natural cause deaths are most common. There is also a higher proportion of deaths classified as 'other non-natural' among the female cases compared against male. These deaths generally involve drugs, which may be prescription such as methadone, illicit such as cocaine, or a combination of both. Classification of these deaths can be problematic, in particular understanding whether the deceased intended to take their life.

The PPO has recently witnessed an increase in drug-related deaths, which includes both male and female prisoners. The issues involved in these deaths are varied, and are beyond the scope of this bulletin, so will be covered in a specific PPO Learning Lessons publication on drug-related deaths to be published in 2017-18.

Against that background, this bulletin focuses on the largest category of female prisoner deaths: those that were clearly self-inflicted. The PPO has completed a total of 47 investigations into self-inflicted deaths among female prisoners, with a further 11 such investigations underway as of the end of December 2016. Nearly all these women (39) took their lives by hanging, this method accounted for almost all of the increase in these deaths over 2015-2016.

The bulletin seeks to draw out learning from nineteen PPO investigation reports into self-inflicted deaths of female prisoners that took place over 2013 to 2016. The reports were analysed thematically, focusing primarily on prison safer custody processes and practice. A review of recent PPO recommendations found that, among the previous three years of reports,¹⁷ all but two

contained formal recommendations to the prison. Consistent with reports into self-inflicted deaths among male prisoners over the same period, the most common recommendations are related to self-harm and suicide prevention procedures, the emergency response and mental health provision.

Themes

The reports reviewed sought to identify good practice, and often found that care from individual staff was very good. But weak practice and basic failings were also highlighted. These findings align with themes identified and addressed in previous PPO publications.

Effectively **identifying, monitoring and responding** to risk is central to preventing prisoners from killing themselves. A previous PPO thematic report¹⁸ set out the need to address risk factors for suicide and self harm. The cases reviewed provide more recent examples where risk was not handled appropriately with the most serious consequences in some instances.

The cases also demonstrate the difficulties prisons face in dealing with particular risks, among them **mental ill health and bullying**, the latter often being drug-related as the reports highlight. The challenge of meeting the needs of prisoners with mental ill health was explored in more detail in a recent PPO thematic report.¹⁹

The **Assessment, Care in Custody and Teamwork (ACCT)** process provides the procedural framework for the management of suicide and self harm risk in prison. The cases reviewed provide more examples of failure to implement the process properly or to manage its use effectively, in line with learning previously disseminated in another PPO publication on the self-inflicted deaths of prisoners subject to ACCT monitoring.²⁰

The cases reviewed also demonstrated the need for an effective **emergency response**, which may mean the difference between life and death.

These themes are discussed below, with illustrative case studies.

Identifying, monitoring and acting on risk

We have previously commented²¹ on prisons' overreliance on subjective assessments of risk based on presentation, as opposed to objective evidence of risk. Prison staff should proactively assess risk, taking into account all known risk factors and personal triggers, as well as how an individual presents to staff.

Cases reviewed for this new bulletin looking specifically at female prisoners showed similar overreliance on presentation, but also, paradoxically, identified cases where the prisoner's presentation – distressed and having thoughts of self-harm – was not adequately considered.

Certainly, the circumstances of each case were different. However, some broad risk 'trajectories' emerged. Some took their lives following a particular trigger point such as sentencing; others represented more of an ongoing raised risk and, more exceptionally, some had no obvious triggers or warning signs that indicated their risk of suicide.

While each case will have presented the prison with particular and unique challenges, there were commonalities in the issues around risk management.

Problems of **risk identification and monitoring** included: not giving proper consideration to the possible impact of a known trigger; not ensuring the input from specialist professionals such as healthcare and mental health professionals who could contribute to risk monitoring; failing to include personal triggers in the ACCT; adding inappropriate triggers such as issues that are ongoing for the prisoner; and lack of continuity of ACCT case manager.

Problems with attempts at **risk reduction** among prison staff included: setting inappropriate caremap actions; closing ACCTs at inappropriate times and not holding post-closure reviews; and setting observation levels too low or undertaking them at regular, predictable intervals. Some of these are discussed further under theme four: implementation of the ACCT process.

There was also evidence of staff inappropriately using punitive approaches such as the adjudication process and the Incentive and Earned Privilege scheme to try to address instances of self-harm or manifestations of distress. The PPO has previously highlighted that young, difficult to manage, prisoners can be a higher suicide risk when faced with ongoing loss of privileges.²² The case of Ms A provides a further example of this along with other issues around risk management.

Case study A

Ms A was 24 years old. She had served several short prison sentences and had a history of mental illness, difficult familial relationships, self-harm and substance misuse. She was described by prison staff as impulsive, challenging and immature.

During her time in prison she was involved in bullying, both as a victim and perpetrator, and she alleged a sexual relationship was taking place between her and a prison officer. She took medication for depression and successfully underwent detoxification during her final sentence. She self-harmed in prison by cutting, at times frequently. Her behaviour was regarded as poor and she lost privileges, being placed on basic regime on a number of occasions prior to her death.

Ms A was identified as being at risk of suicide and self-harm on reception to prison. Her Person Escort Record from court indicated she had self-harmed that month, was dependent on alcohol and suffered from depression and other mental health issues. Prison staff opened an ACCT under which she was monitored until her death.

There was some good practice in her management, but the PPO investigation found the quality of risk assessment was often inadequate. Ms A was consistently assessed as being low-risk at 14 consecutive reviews, with no evidence that the risk assessment took into account changes in her mood, discipline procedures which meant she was spending more time locked in her cell, or her self-harm. Incidents of bullying occurred with Ms A as victim or perpetrator but also failed to prompt a raised risk rating, despite the fact bullying was identified as a trigger for self-harm in her ACCT.

When she disclosed she had been raped while in the community before entering prison, this was not recorded on her ACCT paperwork. Following a later review meeting in which she discussed this and expressed to staff that she “did not want to be here any more” and wanted to hurt herself, her risk was rated low and her observations remained the same. Further, she was allowed to keep a supply of sleeping tablets on which she attempted to overdose and was given a razor, despite her ACCT advising against this.

Other prisoners found Ms A hanged in her cell. Staff administered emergency treatment and she was taken to hospital, but she died the next day.

The investigation found staff had inappropriately, if unintentionally, considered Ms A to be at low risk of suicide by focussing narrowly on what they correctly assessed as her high risk of self-harm. ACCT relates to the risk of suicide as well as that of self-harm, so Ms A’s risk rating should have been increased on a number of occasions in relation to her suicide risk. Recommendations were made on the ACCT process, ensuring decisions to allow prisoners to possess medication were endorsed by full risk assessments, and the response to medical emergencies.

Lessons to be learned

- Prisons should ensure vigilance in risk management, proactively identifying suicide and self-harm risk based on established risk factors and triggers particular to the individual, as well as their presentation to staff;
- Risk monitoring should involve relevant professionals from different disciplines and especially where the woman is receiving routine or substantial input from their services;
- Beyond monitoring, prisons should take appropriate steps to reduce identified risks, including setting caremap actions that are detailed, specific, meaningful and time-bound; and
- Prisons should consider the risks associated with withdrawing privileges when prisoners are being monitored on the ACCT process.

Role of mental health

Mental ill health is a common issue identified in PPO investigations, explored in-depth in a thematic report in 2016.²³ Mental ill health and some form of treatment in prison was typical among the cases reviewed, which also included women who were awaiting a possible transfer to a secure mental health hospital. These cases highlighted the difficulties of adequately protecting and caring for women who were experiencing a mental health crisis or psychotic episode or symptoms, which the prison environment may itself have contributed to or exacerbated.

In a number of cases, the investigation identified that there was a lack of urgency or timeliness in the actions taken by mental healthcare staff. Examples include delays in undertaking an assessment (or in some cases not undertaking one at all), delays in appointing a mental health care coordinator and failing to provide cover for the prisoner's mental health care coordinator.

Looking across the cases more broadly, the investigations often found that decision making around mental health was sound, and care from individual healthcare staff was good. However, a number of issues emerged relating to the delivery of care, or the role of the mental health service in broader management at the prison. There were cases where the mental health care was not found to be equivalent to that the woman could have expected to receive in the community.

A clear theme of poor joint working between mental health and custodial staff, or weak integration of mental health care into the prison emerged from the cases. Typically this related to information sharing, including limited input of mental health care professionals into ACCT reviews, or insufficient information on the woman's healthcare being incorporated into her ACCT document.

There was also evidence these failings were compounded by a lack of clarity around roles and responsibilities. Some mental health staff were found to view the ACCT process as primarily a custodial process and responsibility, and some prison officers were unaware they could refer a prisoner for a mental health assessment.

The case below illustrates a number of issues around mental health care in prison, information sharing, joint working and effective risk management.

Case study B

Ms B had a long history of mental illness and had received inpatient treatment, at times threatening violence to others and damaging property. She had a diagnosis of emotionally unstable personality disorder, suffered from paranoia and sometimes heard voices. She had a history of psychotic phases, often self-harmed and sometimes intended to end her life.

Ms B was remanded into custody in 2014. A transfer application to a secure mental health hospital was made, her community hospital bed having been reallocated because of her risk to other patients and staff. It was her first time in prison.

On arrival in prison, she resided in the prison healthcare unit for three days, until staff moved her to the less noisy segregation unit to help her sleep. During her few days in prison Ms B self-harmed by different means and repeatedly expressed to staff that she wanted to die. Staff found her challenging and volatile. She assaulted an officer on her fourth day in custody, saying later that she thought he was talking about her to other prisoners, and told staff that she had stopped taking all her medication, believing that they were trying to poison her. On the day of her death, she told a mental health nurse she was experiencing poor sleep, reduced appetite, paranoia and fluctuating moods. She also said that she was scared and anxious about being in prison and that her hallucinations worsened when she was stressed.

A couple of hours after she was moved to the segregation unit, Ms B was found collapsed on her bed with a plastic bag on her head. Attempts to resuscitate her by staff and paramedics were unsuccessful. It was her fifth day in prison.

Ms B did not receive a referral to a consultant psychiatrist nor was she allocated a mental health care coordinator. The clinical reviewer concluded that "despite her deteriorating state... no one showed any sign of urgency in recognising that she needed more care than was available".

There were numerous issues around information sharing. Some staff, including the officer who completed her initial ACCT assessment, had

not read her detailed historic mental health information provided by community mental health. There was a lack of input from mental health staff into ACCT reviews and custodial staff had limited access to information about the mental health care she was receiving; some said they were denied access to her medical records (whereas others did not), and there was no clear protocol at the prison to deal with medical confidentiality.

Advice to remove items from her cell that she might use to harm herself was not kept in her ACCT document. This advice was initially recorded on a sharing of risk information form completed by a mental health nurse the day before her death. It appeared that the form was not in the ACCT document, as it should have been, and no action was taken. The following day, Ms B was subject to a mental health assessment to ascertain her suitability for a move to the segregation unit to help her sleep, and to participate in the adjudication process for assaulting the officer the previous day. The notes of mental health in-reach indicated her mood could change rapidly and unpredictably, recommended observation levels of four times per hour, and noted that anything she could smash or swallow should be removed from her cell. However, no one wrote anything in the ACCT, which was the only document staff in the segregation unit could access when she moved there that morning. The PPO considered that the item she used to take her life would have been removed from her cell had the information from staff been shared.

The investigation identified a range of issues with the care and management of Ms B and made four recommendations to the prison, relating to the management of prisoners with complex and long-standing mental health problems, the need for mental-health trained staff in the inpatient unit, segregation of prisoners identified as at risk of suicide and self-harm, with complex mental health problems or being assessed for transfer to a secure hospital, and ACCT procedures. The report ultimately concluded that “Ms B did not get sufficient support from trained mental health staff and there was a general lack of input from mental health into the prison’s inpatient unit”.

Lessons to be learned

- Prison mental health services should ensure that all cases are treated with an appropriate degree of urgency, and avoid delays with assessment and care; and
- Prisons should ensure there is clarity around roles and responsibilities of custodial and mental health staff and otherwise ensure there is efficient and timely information sharing to protect vulnerable female prisoners. Bureaucratic, cultural or other barriers to effective joint working between custodial and mental health staff should be addressed.

Bullying

Where bullying featured, it included cases with allegations made by families and other prisoners, cases where bullying was suspected by staff and some where the PPO investigation found evidence of bullying. Bullying can cause detriment to both victim and perpetrator. While it can be difficult to know to what extent it has contributed to any specific death, bullying is often inter-related with other risk factors such as mental ill-health, drug abuse and violence.

One case reviewed involved a woman who was subject to abuse and sexual bullying on account of her transgender status. Bullying of this nature has been explored as part of a recent PPO publication on transgender prisoners.²⁴

Among the remaining cases where the investigation found evidence the deceased was a victim of bullying, all of which related to deaths that occurred over 2015-2016, there was evidence of a link between bullying and illicit drugs.

For example, a prisoner who was high profile due to the nature of her offence, and often abused by other prisoners, was known to use illicit drugs as a coping mechanism. She engaged in relationships with dominant women who could offer her access to drugs and protection from other prisoners, including one woman known to have bullied her previously and with whom she argued on the day of her death. The PPO did not feel sufficient action was taken to address what appeared to be exploitative relationships and made recommendations on both this and on the prison drug supply reduction strategy.

In other cases, including the case study below, there was evidence of bullying over drug debt. For example, a woman was involved in many incidents and faced disciplinary procedures for fighting, being abusive and diverting her medication. She was moved to another spur of the unit where she lived two to three months before her death, having argued with one prisoner about drugs and fought with another on the day of her death. The investigation concluded the bullying incidents had been dealt with appropriately in this particular case, but raised concerns about the wider culture of bullying on the unit and the prison's capacity to address it.

Another woman had taken her life earlier that month on the same unit and the investigation found she too was involved in the supply of drugs. The woman had not alleged bullying herself, although a relative called the prison to say she was being pressured into smuggling drugs during visits. The woman was subject to two periods of closed visits that upset her, one starting a week before her death.

Staff at this unit felt they did not have adequate resource to police the medication hatch properly or ensure the safety of prisoners. There was some indication of a similar issue at another prison, where prisoners told the PPO that women concealed or exchanged their medication, either out of choice or due to pressure, and that there were no proper checks that medication was taken by the person for whom it had been prescribed.

Since it is not always possible to determine whether bullying was a material fact in relation to the death, the PPO does not always make recommendations to the prison around the handling of bullying allegations. In one instance, where the PPO found that staff had intervened promptly, putting in place measures to protect the woman until what would have been her release date, the investigation concluded that the woman's allegations of bullying had been handled well. However, this was not the case for Ms C below.

Case study C

Ms C was in prison for the first time serving a sentence for a nonviolent offence. Her lifestyle was chaotic and she had experienced mental illness, substance misuse and abusive relationships. She was prescribed medication for anxiety, depression and psychosis, as well as methadone for heroin withdrawal while in prison.

On several occasions, Ms C made reports to staff she was being bullied, the first of which was made to three healthcare staff. None of the staff submitted an intelligence report to the security department.

The following month, custodial staff reported to the security department that they had observed Ms C leaving the canteen when a particular prisoner arrived, and that they suspected she had drugs debt. Several days later she had a fight with two prisoners and told staff they were bullying her over a tobacco debt. An intelligence report was made but Ms C would not make a statement, so no further action was taken.

Ms C disclosed problems with other prisoners to custodial staff on two occasions, one of which was at an ACCT review meeting. The meeting recorded this and noted these problems would hopefully be resolved, but did not state how this would be achieved or give any further details. She was named on a Challenging Behaviour Incident Form as the victim of bullying by two women and staff believed one of the women was taking Ms C's medication. She denied it and no further action was taken.

The investigation found that, on the four occasions, Ms C reported bullying to healthcare staff, but no one submitted an intelligence report. Prison staff were told verbally on one occasion but there was no evidence this was followed up. Similarly, custodial staff witnessed four potential incidents of bullying of Ms C but only one Challenging Behaviour Incident Form was completed, and there was no evidence of investigations or that bullying was properly discussed at her ACCT reviews. The PPO recommended that the prison should ensure that allegations of bullying were investigated in line with the local violence reduction policy.

The investigation also found two issues with the way staff responded to the medical emergency, and a number of other recommendations were made in relation to the ACCT process, the management of prisoners with complex needs and the local safer custody policy.

Lessons to be learned

- Prisons should properly investigate allegations of bullying from prisoners and family members and also incidents of potential bullying witnessed by staff;
- Prisons should ensure officers are vigilant for signs of intimidation or drug misuse to protect prisoners' safety. Bullying is often related to drug debts, so where drug activity is suspected, staff should be on the look out for signs of bullying; and
- Prisons should ensure they have in place effective supply reduction strategies to reduce the availability of illicit drugs.

Implementation of the ACCT process

ACCT is the care-planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Some of the key features of the process are regular, multi-disciplinary case reviews, prisoner checks/observations, which should be undertaken at irregular (i.e. unpredictable) intervals, and the production of a caremap to identify the prisoner's most urgent issues and how they will be met. A case manager is appointed from the outset and it is desirable that there is consistency in this role, so that one person has oversight of the prisoner's problems and how they are being addressed over time.

Prisoners whose cases were reviewed were typically subject to ACCT procedures at some point during their time in prison and, where this was the case, the PPO made recommendations to the prison about the way the process had been delivered. These related to all parts of the ACCT 'cycle', from opening an ACCT through to post-closure review, and individual cases tended to highlight a number of different issues or problems.

A lack of a multi-disciplinary approach to the process emerged as a strong theme, most obviously exemplified by a lack of attendance from anyone other than custodial staff at review meetings, and particularly where the input from mental health or substance misuse workers who knew the prisoner would clearly have been valuable. There were also instances where entries into the ACCT record were not completed by external professionals who had visited the prisoner.

Evidence also suggested that the ACCT process was sometimes not sufficiently personalised to the individual. Their specific needs, problems and triggers, such as visits from an abusive partner, were not always identified or included, and across the cases we considered, review meetings often did not give appropriate consideration to the full range of issues relevant to the individual. On occasions, review meetings failed to identify or document their issues.

A number of issues with prisons' handling of the caremap element of the ACCT process emerged. There were instances where caremap actions had not been reviewed or updated, and where actions that were clearly ongoing had been marked as completed. Some caremaps were found not to fully reflect the range of issues relevant to the particular prisoner; example, the support services they were receiving within the prison or disclosures they had made at review meetings relating to bullying or historical sexual assaults. Actions specified in caremaps were sometimes at odds with the Prison Service Instruction (PSI) guidance which stipulates they should be detailed, specific, meaningful and time bound. For example, an investigation found the prisoner's low mood was the only issue recorded in her caremap, with only one accompanying action - to raise her mood.

The ACCT process includes provision for enhanced case management for prisoners whose challenging behaviour requires more intensive input to manage their increased risk of suicide and self-harm. It provides for greater senior management oversight of the prisoner's management, for example a requirement for a custodial manager or a more senior manager to chair the ACCT case reviews. Triggers for escalation to enhanced status include: being under the care of the mental health team, spending time in the healthcare unit, repeated suicide attempts, being subject to constant supervision, requiring a multiple-officer unlock, committing disciplinary offences and representing a threat to staff.

In some of the more complex cases reviewed, the investigation found that staff should have considered the possibility of escalating to enhanced case management, which would have ensured greater senior management oversight for some of the more vulnerable prisoners with complex needs.

This review found cases where the ACCT closure process had not been followed properly, for example, where outstanding caremap actions had not been completed (contrary to both the PSI and common sense), where the prisoner had recently self-harmed or expressed suicidal thoughts, or a trigger noted in the ACCT document, such as a court appearance, was pending.

The case study below illustrates these findings - much of the care from individual staff was found to be good, but as the ACCT process was not implemented as intended in a number of respects, the overall management of the prisoner was inadequate. The overarching conclusion drawn was of a lack of clarity and coordination in her care and management, failings which go to the heart of the ACCT process.

Case study D

Ms D was serving the latest of a number of short sentences for non-violent offences. She had been in prison several months and was not due for imminent release. She had a history of depression and substance misuse and was prescribed anti-psychotic medication in prison.

Ms D had a diagnosis of borderline personality disorder and was described by staff as having complex needs. She self-harmed prolifically when in prison, mostly using unattached ligatures but also other means. She reported feeling low from being back in prison and found that her mood would often drop suddenly and unpredictably. She attributed her self-harm to shame and guilt around historical sexual abuse, and also told a friend that she “liked the buzz” of self-harm.

Ms D died in hospital from a brain injury, two days after tying a ligature around her neck in her prison cell.

It appears likely that Ms D did not intend to take her own life. The PPO investigation concluded that given the nature and frequency of her self-harming it would have been difficult for staff to prevent her death. It also found that much of the care Ms D received from individual staff was good. However, two recommendations were made to the prison, related to the ACCT process and the care of prisoners subject to the Care Programme Approach.

Ms D’s caremap included actions that were not appropriate to reduce her risk, and it was not clear which actions had been completed. Decisions taken at review meetings had sometimes not been recorded, and there was no consistent case manager, hence no one had oversight of how her risk was developing and being addressed over time. Approaches staff took to reduce her self-harm were uncoordinated; staff continued approaches they had found to be ineffective, since no one had recorded their decisions not to use them again.

Case reviews were not sufficiently multi-disciplinary, with her mental health care coordinator attending only one out of twenty-eight reviews, and sometimes only one staff member present. During the PPO investigation, staff gave inconsistent accounts on why there had been such limited input from mental health.

The investigation found that Ms D should have been considered for enhanced case management under the ACCT process, given her complexities and problems. A senior custody officer had raised this with their manager shortly before her death but no action was taken.

Lessons to be learned

- Prisons should implement the ACCT process effectively, as intended by the PSI and with appropriate management oversight;
- Prison staff should be provided with regular refresher training on the ACCT process;
- Prisons should ensure caremap actions are appropriate for reducing risk and that progress in delivering the objectives of caremap actions is actively monitored, with progression through the ACCT process being dependent on this and with consistency of case manager where possible; and
- Prisons should use enhanced case management to bring greater senior engagement, oversight and responsibility for keeping the most complex and challenging female prisoners safe.

Emergency response

In instances of attempted suicide or serious self harm, rapid and timely emergency responses are critical. Staff clearly can be distressed and shocked when confronted by such situations, which makes their training in, and understanding of, the actions they need to follow essential. It is of considerable concern that it was common for the investigations to identify that staff response was not in line with mandatory procedures set out in PSIs.

The most common failing was custodial or medical staff having not used the correct emergency response code²⁵ when radioing the control room, but other issues were also identified. Some related to equipment; for example, custodial staff not having a cut-down tool on their person, or emergency medical bags not containing vital equipment.

Among the cases was a prisoner who was left alone and unconscious while a nurse ran to collect the medical bag, instead of attending to the prisoner and requesting another member of staff bring the bag to her. There were also instances where response protocols had not been established so that the 999 operator would not immediately dispatch an ambulance, and PPO sometimes found that resuscitation was attempted despite the onset of rigor mortis, which is undignified for the deceased and can be traumatic for staff.

Case study E

Ms E was in prison serving a life sentence for a serious crime against a family member. She attempted to hang herself after being sentenced and was monitored under the ACCT process on 11 occasions.

Around two years into her sentence, an officer conducting the 6am roll check observed that Ms E was not in her bed, but assumed she was in her shower room and moved on. Around an hour later, another officer conducting a roll call at the start of his shift knocked on her door, then called her name and kicked the door but got no response. He then went to the office and brought a colleague with him to the cell, being reluctant to enter alone in case Ms E was showering.

When they entered the cell, they found Ms E had hanged herself in her shower cubicle with a belt. One of the officers radioed a Code Blue to the control room, and the officers removed the belt and lowered Ms E to the floor, where one of them began resuscitation. They were joined by another officer who shared the resuscitation, plus both the night orderly officer who had been finishing his shift and the incoming orderly officer for the day shift. The night orderly asked an officer to radio for an ambulance. Healthcare staff arrived with medical equipment and took over the resuscitation. Ambulance staff arriving on the scene identified partial rigor mortis and pronounced Ms E dead.

PPO identified a number of deficiencies with the emergency response. As specified in the local security strategy, the officer conducting the 6am roll call should have accounted for Ms E and if unable to do so, raised an alarm.

Contrary to PSO 64/2011,²⁶ the night shift officer was not carrying a cut down tool, not having undertaken the training required by the prison. There was also a three minute delay in despatching an ambulance, as the control room waited for a manager to reach the scene and specifically request one, rather than calling an ambulance immediately on receiving the Code Blue as PSO 03/2013 stipulates.

A breathing mask was missing from the emergency response bag and a nurse had to

run and collect a spare. This would have made no difference to the outcome in this case, as it was brought too late, but this could be critically important in other emergencies.

Staff attempted resuscitation even though they knew Ms E was dead. There was no local policy to guide staff on when to attempt resuscitation and the PPO recommended that the prison provide this.

Lessons to be learned

- Prisons should ensure all prisoners are accounted for during roll calls;
- Prisons should ensure all staff, including night shift staff, carry cut-down tools;
- Prisons should ensure that ambulances are despatched without delay in the event of medical emergency;
- Prisons should ensure that staff bring all relevant emergency equipment promptly to the scene of an emergency; and
- Prisons should ensure staff are aware of recently issued guidance²⁷ on when it is appropriate to attempt resuscitation.

Conclusion

The genesis of this bulletin lay in concerns at the recent increase in deaths of female prisoners. It is based on a review of a snapshot of recent reports into self-inflicted deaths and therefore cannot explain what lies behind the increase; this would require a much broader evidence base. In the context of the increasing numbers of deaths among female prisoners, however, we feel the lessons contained here - many of which are a reminder to prisons of what already appears in their own rules and processes and have been made before by the PPO - are worth reemphasising. We hope too, that they will inform the broader discussion of the effective and compassionate management of female offenders. To this end, we will work closely with the Ministry of Justice, the National Prison and Probation Service and the Independent Advisory Panel on Deaths in Custody, in particular their rapid information gathering exercise, to identify learning and options for policy development.

Endnotes

1. Ministry of Justice (2016) Deaths in Prison Custody 1978 to 2015: Table 1.5: Self-inflicted deaths in prison custody and rates by gender since 1978, England and Wales. London: Ministry of Justice. Available online on at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/562902/safety-in-custody-deaths-dec-15-final.xls
2. Ministry of Justice (2016) Population bulletin: weekly 30 December 2016. Available online at <https://www.gov.uk/government/statistics/prison-population-figures-2016>
3. Ten single-sex prisons are operated by the National Offender Management Service. Among the two privately operated prisons, HMP/YOI Bronzefield is female-only, whereas HMP/YOI Peterborough is a dual-purpose prison which holds male and female prisoners in separate accommodation.
4. See note 1.
5. Prison Service Order (PSO) 4800: Women Prisoners (issued 28-04-2008).
6. Light et al. (2013) 'Gender differences in substance misuse and mental health amongst prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners' London: Ministry of Justice Analytical Series. Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf
7. *Ibid.*
8. McManus et al. (2009), cited in Light et al. (2013) at page 18.
9. Ministry of Justice (2016) Safety in Custody Statistics: Self-harm annual tables, 2004 – 2015. Available online at: <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2016>
10. *Ibid.*
11. Corston, J. (2007) 'The Corston Report: a report by Baroness Jean Corston of a review of women with particular vulnerabilities in the prison system', London: Home Office. Available online at: <http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf>
12. House of Commons Justice Committee (2013) 'Women offenders: after the Corston Report. House of Commons Justice Committee', Second Report of Session 2013- 2014. Available online at: <https://www.parliament.uk/documents/commons-committees/Justice/Women-offenders.pdf>
13. The Gender Equality Duty came into force in 2007. It applies to all public authorities in England, Scotland and Wales, requiring them to eliminate gender-based discrimination and promote equality between men and women when carrying out their functions.
14. Ministry of Justice (2016) Prison Safety and Reform, London: Ministry of Justice. Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565014/cm-9350-prison-safety-and-reform-_web_.pdf
15. *Ibid.*
16. See note 5.
17. This includes the last three years of reports at the time of writing, representing the period inclusive of December 2013 to November 2016.
18. Prisons and Probation Ombudsman (2015) *Risk factors in self-inflicted deaths in prisons*. Available online: http://www.ppo.gov.uk/wp-content/uploads/2014/07/Risk_thematic_final_web.pdf#view=FitH
19. Prisons and Probation Ombudsman (2016) *Prisoner mental health*. Available online at: <http://www.ppo.gov.uk/wp-content/uploads/2016/01/PPO-thematic-prisoners-mental-health-web-final.pdf#view=FitH>
20. Prisons and Probation Ombudsman (2014) *Self-inflicted deaths of prisoners on ACCT*. Available online at: http://www.ppo.gov.uk/wp-content/uploads/2014/07/ACCT_thematic_final_web.pdf#view=FitH
21. *Ibid.*
22. Prisons and Probation Ombudsman (2013) *Learning Lessons Bulletin Fatal Incidents Issue 4: Basic regime*. Available online: http://www.ppo.gov.uk/wp-content/uploads/2014/07/Learning_lessons_bulletin_FII_issue_4_Basic_regime_web.pdf#view=FitH

23. See note 19.
24. Prisons and Probation Ombudsman (2017) *Transgender Prisoners*. Available online: http://www.ppo.gov.uk/wp-content/uploads/2017/01/PPO-Learning-Lessons-Bulletin_Transgender-prisoners_Final_WEB_Jan-17.pdf#view=FitH
25. Prison Service Instruction (PSI) 03/2013: Medical Emergency Response Codes, stipulates that 'Code Red' should be used for blood / burns and 'Code Blue' for breathing / collapses. All cases reviewed should have been 'Code Blue'.
26. Prison Service Instruction (PSO) 64/2011: Management of prisoners at risk of harm to self, to others and from others (Safer Custody).
27. European Resuscitation Council (ERC) Guidelines for Resuscitation (2015). Available online: <https://cprguidelines.eu/>. NOMS, the RCN and the RCGP jointly issued guidance on when not to perform resuscitation in September 2016.

The Prisons and Probation Ombudsman investigates complaints from prisoners, young people in secure training centres, those on probation and those held in immigration removal centres. The Ombudsman also investigates deaths that occur in prison, secure training centres, immigration detention or among the residents of probation approved premises. These bulletins aim to encourage a greater focus on learning lessons from collective analysis of our investigations, in order to contribute to improvements in the services we investigate, potentially helping to prevent avoidable deaths and encouraging the resolution of issues that might otherwise lead to future complaints.

PPO's vision:

To carry out independent investigations to make custody and community supervision safer and fairer.

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Summary of lessons to be learned

Identifying, monitoring and acting on risk

- Prisons should ensure vigilance in risk management, proactively identifying suicide and self-harm risk based on established risk factors and triggers particular to the individual as well as their presentation to staff;
- Risk monitoring should involve relevant professionals from different disciplines and especially where the woman is receiving routine or substantial input from their services;
- Beyond monitoring, prisons should take appropriate steps to reduce identified risks, including setting caremap actions that are detailed, specific, meaningful and time bound; and
- Prisons should consider the risks associated with withdrawing privileges when prisoners are being monitored on the ACCT process.

Role of mental health services

- Prison mental health services should ensure that all cases are treated with an appropriate degree of urgency, and avoid delays with assessment and care; and
- Prisons should ensure there is clarity around roles and responsibilities of custodial and mental health staff and otherwise ensure there is efficient and timely information sharing to protect vulnerable female prisoners. Bureaucratic, cultural or other barriers to effective joint working between custodial and mental health staff should be addressed.

Bullying

- Prisons should properly investigate allegations of bullying from prisoners and family members and also incidents of potential bullying witnessed by staff;
- Prisons should ensure officers are vigilant for signs of intimidation or drug misuse to protect prisoners' safety. Bullying is often related to drug debts, so where drug activity is suspected, staff should be on the look out for signs of bullying;
- Prisons should ensure they have in place effective supply reduction strategies to reduce the availability of illicit drugs.

Implementation of the ACCT process

- Prisons should implement the ACCT process effectively, as intended by the PSI and with appropriate management oversight;
- Prison staff should be provided with regular refresher training on the ACCT process;
- Prisons should ensure caremap actions are appropriate for reducing risk and that progress in delivering the objectives of caremap actions is actively monitored, with progression through the ACCT process being dependent on this and with consistency of case manager where possible; and
- Prisons should use enhanced case management to bring greater senior engagement, oversight and responsibility for keeping the most complex and challenging female prisoners safe.

Emergency response

- Prisons should ensure all prisoners are accounted for during roll calls;
- Prisons should ensure all staff, including night shift staff, carry cut-down tools;
- Prisons should ensure that ambulances are despatched without delay in the event of medical emergency;
- Prisons should ensure that staff bring all relevant emergency equipment promptly to the scene of an emergency; and
- Prisons should ensure staff are aware of recently issued guidance on when it is appropriate to attempt resuscitation.