

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Krysha Bailey a prisoner at HMP Eastwood Park on 8 August 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Ms Krysha Bailey died in hospital on 8 August 2016 as a result of hypoxic ischaemic encephalopathy after she tied a ligature around her neck at HMP Eastwood Park, six days earlier. She was 37 years old. I offer my condolences to Ms Bailey's family and friends.

Ms Bailey harmed herself prolifically in prison and had spent time previously at Eastwood Park when she demonstrated similar behaviours. In the nine days she spent at Eastwood Park before her death, staff recorded 28 incidents of significant self-harm, mostly by tying ligatures around her neck, on several occasions to the point of stopping breathing and losing consciousness. The assessment of Ms Bailey's risk and management of her care lacked coherence and consistency and she was managed less intensively than during her previous time at the prison. Suicide and self-harm prevention procedures were not sufficiently multi-disciplinary, and, critically, did not involve the mental health team, even though her mental ill-health had been the subject of numerous interventions previously. The frequency of observations was too low to address her determination to hang herself. When staff found her, they did not radio a code blue promptly in line with national instructions.

We have raised our concerns about previous deaths on Kinnon Unit and the Governor has commissioned an internal review. I would be grateful for a report on the review's progress.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman

May 2017

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Summary

Events

1. Ms Bailey had spent time at Eastwood Park before. She had a history of mental health issues, attempted suicide, prolific self-harm and alcohol and substance misuse. Between February and May 2016, Ms Bailey self-harmed over 60 times at Eastwood Park. Staff and the mental health team supported her under ACCT suicide and self-harm prevention procedures in a unit for women in crisis.
2. On 25 July, Ms Bailey was returned to Eastwood Park after breaching an Anti-Social Behaviour Order and committing further offences. She was housed in Kinnon Unit, the detoxification unit, because of her substance misuse issues. On 27 July, staff moved Ms Bailey to another spur in Kinnon Unit after she alleged she had been bullied.
3. She self-harmed 28 times in the nine days between her admission and her death, mostly by tying a ligature around her neck and on several occasions, losing consciousness. Staff managed Ms Bailey under ACCT procedures but there was minimal input from the mental health team, unlike during her previous period at Eastwood Park.
4. On 2 August, an officer found Ms Bailey unconscious in her cell with two ligatures tied around her neck and called for medical assistance. Staff immediately began cardiopulmonary resuscitation. A medical emergency code blue was called six minutes later. When the paramedics arrived, they found a faint pulse and took Ms Bailey to hospital. Ms Bailey did not recover and died on 2 August 2016.

Findings

5. Ms Bailey was appropriately identified as at risk of suicide and self-harm when she arrived at Eastwood Park and she saw a member of the mental health team two days afterwards. But despite her continuing and escalating acts of self-harm, prison staff did not share any concerns with the mental health team who were not involved in her risk assessment and care.
6. Ms Bailey had a high risk of suicide and self-harm. Staff did not manage the risk she posed to herself effectively and did not set observations at an appropriate frequency despite her clear risk factors and prolific and significant self-harm.
7. Ms Bailey's act of self-harm on 2 August, which led to her death, appeared no different to the many times that Ms Bailey had previously tied material tightly around her neck to the point of stopping breathing and losing consciousness. With the benefit of hindsight, we consider that a period of constant supervision was appropriate to ensure Ms Bailey's safety and would have been consistent with the way in which she had previously been managed at Eastwood Park.
8. There were clear deficiencies in assessing Ms Bailey's risk of suicide and self-harm and in operating ACCT procedures to support her. The investigation found that:

- ACCT reviews were not sufficiently multi-disciplinary, and the mental health team should have been involved.
 - There was no clear ACCT careplan to help reduce Ms Bailey's risk and the plan was not reviewed or updated to reflect her continued risk.
 - No one considered whether to manage Ms Bailey under enhanced ACCT case management procedures.
9. In the absence of evidence, we could not conclude whether or not Ms Bailey was the victim of bullying on Kinnon Unit. We are concerned that her location on Kinnon Unit appears to have been a factor in the way in which her risk was managed. We have previously welcomed the Governor's review of Kinnon Unit and the Deputy Director of the Women's Estate's oversight. We would be grateful for an update on progress.
10. There were deficiencies in the emergency response. Staff did not immediately use the correct emergency code when they found Ms Bailey. This resulted in a short delay in medical emergency equipment being brought to Ms Bailey's cell and a delay in an ambulance being called. Staff resuscitated Ms Bailey and took her to hospital, where she later died.

Recommendations

- **The Governor should ensure that staff fully consider all risk factors when assessing prisoners at risk of suicide and self-harm. Constant supervision should be considered when indicated, in line with guidance in PSI 64/2011.**
- **The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:**
 - **Holding multi-disciplinary ACCT reviews with continuity of case management and involving all staff who can contribute to the care of a prisoner at risk.**
 - **Assessing prisoners' risk of self-harm in line with national instructions.**
 - **Using the enhanced case review process, when appropriate.**
 - **Setting effective caremap objectives which reflect decisions from reviews, are specific and meaningful, and which identify who is responsible for them and when they have been completed.**
- **The Governor and Head of Healthcare should ensure that prison staff, healthcare and mental health teams share all relevant information to enable accurate ACCT assessments and subsequent risk management of prisoners at risk of suicide and self-harm to take place, including consideration of the prisoner's location and availability of appropriate interventions.**
- **The Deputy Director of the Women's Estate should provide the Ombudsman with an update on progress about the review of Kinnon Unit within one month of this initial report.**

- **The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including calling an appropriate emergency medical code immediately when indicated.**

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Eastwood Park informing them of the investigation and asking anyone with relevant information to contact her. No one contacted him.
12. The investigator obtained copies of relevant extracts from Ms Bailey's prison and medical records and CCTV from 2 August 2016.
13. NHS England commissioned a clinical reviewer to review Ms Bailey's clinical care at the prison.
14. The investigator interviewed 12 members of staff and one prisoner at Eastwood Park on 13 and 19 October 2016. The clinical reviewer joined him for the interviews.
15. We informed HM Coroner for Avon of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Ms Bailey's partner to explain the investigation. Ms Bailey's partner did not have any specific questions for us to consider.
17. Ms Bailey's partner received a copy of the initial report and chose not to comment or provide feedback.

Background Information

HMP Eastwood Park

18. HMP Eastwood Park in South Gloucestershire opened as a female prison in March 1996. Unit 8, known as Kinnon Unit, is the stabilisation unit for women with substance misuse problems. The unit holds 85 women and has 24 hour healthcare cover. Around 70% of women arriving at Eastwood Park are admitted to Kinnon Unit. Residential 4 holds ten women in crisis, including those with mental health issues, those needing hospital transfer, those who harm themselves seriously and whose risk cannot be managed elsewhere in the prison. There is a mental health team in the unit, and they work in partnership with wing staff. The mental health team offers one-to-one sessions, support from a psychologist, psycho-educational groups and more in-depth therapy.) Bristol Community Health and Avon and Wiltshire Partnership Trust provide primary care, mental health care and substance misuse services.

HM Inspectorate of Prisons

19. There was an inspection in November 2016, but the report has yet to be published. Initial feedback noted that there had been three self-inflicted deaths on Kinnon Unit since May 2016. There were weaknesses in the operation of ACCT procedures, particularly due to the lack of multi-disciplinary work. Healthcare staff rarely attended first ACCT reviews unless it was a known mental health client. Caremaps were not used well enough, and in some cases, there was no evidence of them being reviewed or changed. Eastwood Park had recently revised its policy for new arrivals to increase prisoners' PIN credit and wages.

Independent Monitoring Board

20. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to October 2015, the IMB said that mental health services had seen very positive developments, with new staff and a dedicated wing for those with a personality disorder. At the time of issuing their report, the IMB also noted that Eastwood Park had around 40 prisoners on special measures to prevent self-harm. It noted that board members had witnessed many incidences of staff dealing with distressing and challenging situations with care and compassion. Despite this, the IMB noted a worrying increase in the number of self-harm incidents.

Previous deaths at HMP Eastwood Park

21. Ms Bailey was the third prisoner since May 2016 to take her life at Eastwood Park. All three deaths occurred on Kinnon Unit. Since the self-inflicted death of the second prisoner, the Governor commissioned an internal review of Kinnon Unit. The Deputy Director of the Women's Estate accepted our recommendation that he should oversee the review.

Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.
23. Prisons have the discretion to manage the most severely disruptive, volatile and difficult to manage prisoners at risk of suicide and self-harm under an enhanced case review process. Enhanced case reviews are designed to allow staff to respond more flexibly and effectively to the prisoner's individual needs to change the prisoner's behaviour and manage their risk.

Key Events

February to May 2016

24. Ms Bailey had a long and complex history of physical, emotional and mental illnesses, including emotionally unstable personality disorder, post-traumatic stress disorder, anxiety depression, schizophrenia and bipolar disorder. She had a history of attempted suicide, prolific self-harm and substance misuse. She had served a number of sentences, including at HMP Eastwood Park between 2007 and 2010.
25. She served time at Eastwood Park between February and May 2016. Ms Bailey was initially housed on Kinnon Unit because of her opiate and drug dependence. Staff began ACCT monitoring (with five observations an hour) when Ms Bailey tied ligatures made from strips of sheets tightly around her neck, six times in seven hours.
26. The next day, she was moved to Unit 4 because of her high risk of suicide and self-harm, and Kinnon Unit was not considered suitable to manage her risk. She was supported by multi-disciplinary team meetings to assess her risk.
27. The mental health team assessed Ms Bailey. Between February and May 2016, staff recorded more than 60 incidents of significant self-harm, mostly by tying ligatures made from strips of material tightly around her neck, often tight enough to stop her breathing. Staff monitored Ms Bailey's high risk of self-harm under enhanced ACCT case reviews and increased the frequency of observations in line with her risk.
28. Ms Bailey was managed under ACCT procedures (including enhanced case reviews). She was often under constant observation in her cell and was monitored seven times an hour otherwise. Ms Bailey had to wear safer clothing in her cell and staff searched Ms Bailey when she returned to her cell to check she had not hidden material that she could use as a ligature.
29. After a number of mental health interventions and assessments, the mental health team applied for Ms Bailey to be admitted to a psychiatric hospital. Yet, five psychiatric hospitals declined to take her because of her behaviour. She was released in May.

25 July

30. On 25 July, Ms Bailey was sentenced to seven months in custody at HMP Eastwood Park for breaching an anti-social behaviour order, assaulting a police officer and being in possession of drugs. Her person escort record noted her mental health issues and her extensive history of self-harm from 2008 onwards.
31. An officer assessed Ms Bailey's risk and needs. She recorded Ms Bailey's significant history of self-harm. Ms Bailey said she was homeless and her family was not aware that she was in prison. Ms Bailey tied a ligature made from a piece of material around her neck in reception. She said she wanted to kill herself. A healthcare assistant examined her, but did not consider she needed medical treatment.

32. The officer started ACCT monitoring. Staff agreed to observe Ms Bailey five times an hour and have three significant conversations with her each day. Ms Bailey tested positive for cocaine, opiate, benzodiazepine and methadone at her initial health screen, and reception staff decided to house her on Kinnon Unit to address her alcohol and drugs misuse. Ms Bailey had current thoughts of self-harm and said she had previously been treated in a psychiatric hospital four years earlier. The healthcare assistant noted that she had a mental health disorder.
33. Afterwards, a prison GP saw Ms Bailey, who was calm and co-operative. He noted that she had alcohol dependence, drank heavily and had used poly-drug cocktails. Ms Bailey did not appear intoxicated or to have withdrawal symptoms. He noted that Ms Bailey's prescriptions for antidepressants, anti-psychotic medication and methadone should be continued.
34. At 7.00pm, Ms Bailey was moved to Kinnon Unit. The officer recorded that Ms Bailey had phoned her partner, who was her next of kin. By 8.10pm, Ms Bailey had tied two ligatures around her neck, using clothing and torn bed sheets. Staff responded, removed the ligatures and checked Ms Bailey's welfare. They did not consider that she needed medical treatment.

26 July

35. On 26 July, staff noted Ms Bailey seemed settled and they gave her small tasks to keep her busy.
36. A custodial manager assessed Ms Bailey under ACCT procedures. Ms Bailey told him that she did not want to be at Eastwood Park, was an alcoholic and had withdrawal symptoms. She said she felt anxious, she had daily thoughts of self-harm and regularly heard voices that made her self-harm. She spoke positively about her new partner and signed the ACCT consent form, which enabled the prison to contact him to help support her. (Ms Bailey's partner said that no one contacted him.) The custodial manager noted that Ms Bailey was to be monitored five times an hour, and staff were to refer her to the mental health team and the Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS) team for alcohol misuse support.
37. A Supervising Officer (SO), the unit manager, and the custodial manager completed Ms Bailey's first case review after her assessment. No one from the healthcare team, mental health team or the CARATS team attended. The SO recorded Ms Bailey's risk of self-harm as low, despite her self-harming three times since she arrived at Eastwood Park. He said that staff considered that Ms Bailey's self-harm was not as serious as during her previous period in custody. Ms Bailey was also better engaged with staff. He recorded in Ms Bailey's ACCT caremap that Ms Bailey needed to complete her detoxification on Kinnon Unit and that Ms Bailey was referred to the mental health team that day.
38. At 10.15am, Ms Bailey saw the prison chaplain. He noted that Ms Bailey said she felt worthless, had ligatured the night before and felt vulnerable. Ms Bailey's mood was low and she was hearing voices telling her to self-harm. The chaplain discussed with Ms Bailey ways in which she could keep herself occupied to

distract her negative thoughts. A nurse also saw Ms Bailey as part of her detoxification monitoring.

39. Between 3.40pm and 3.50pm, Ms Bailey tied two ligatures around her neck, in quick succession. Staff removed them and the healthcare team examined Ms Bailey but did not consider she needed medical treatment. No one changed Ms Bailey's level of risk and frequency of observations, which remained at five times an hour.
40. Shortly afterwards, a custodial manager completed an ACCT case review with Ms Bailey and introduced himself as her case manager. He had no immediate concerns about Ms Bailey and scheduled an ACCT case review for 28 July. He said that Ms Bailey's case was complex. He said he was unaware that Ms Bailey had a partner, even though the details were in the ACCT record.
41. Less than an hour later, staff removed another ligature from Ms Bailey's neck. The healthcare team examined her but did not consider that she needed medical treatment. Ms Bailey's ACCT observations remained the same.
42. Wing staff spoke to Ms Bailey after she self-harmed. They recorded she was emotional, described the unit as crazy and said she wanted tobacco. A healthcare assistant recorded after removing ligatures from Ms Bailey's neck that she had no concerns about her, that Ms Bailey had shown no breathing difficulties and that she had visible marks around her neck.
43. Around 6.40pm, records noted that Ms Bailey asked staff for some tobacco. We have seen no evidence about whether staff gave her some.
44. At 6.50pm, a SO completed an ACCT case review with an officer and a healthcare assistant after Ms Bailey's earlier self-harm. Ms Bailey did not attend the review. The records do not say why. The SO made no changes to Ms Bailey's risk of self-harm, which was recorded as low. Her level of observations remained at five times an hour, and the caremap actions remained the same.
45. At 6.56pm, Ms Bailey phoned her partner. She told him that she had received his letter and asked him to send her some writing paper and stamps. They said they loved each other.
46. At 7.10pm and 8.30pm, staff attended Ms Bailey's cell and removed ligatures made from clothing from around her neck. Neither incident apparently required medical treatment. Ms Bailey had now tied ligatures around her neck eight times within 24 hours.

27 July

47. At 10.00am, two nurses from the mental health team assessed Ms Bailey. One nurse recorded that Ms Bailey was polite and maintained good eye contact and rapport. She said she was pleased that she had a job on the unit. However, she felt emotionless. Ms Bailey said she did not believe that she was in crisis or that she needed to move to Unit 4. She felt it might destabilise her further. She said she still had thoughts of self-harm and was hearing voices in her head telling her to harm herself. Ms Bailey agreed to try different ways to manage her distressing thoughts. The nurse gave Ms Bailey some distraction packs to use when in her

cell and referred her to the prison psychologist. The nurses noted Ms Bailey did not meet the criteria for Unit 4. They considered Ms Bailey's risk of self-harm was high but less than during her previous sentence. Nursing staff continued to monitor Ms Bailey's detoxification progress and she continued to attend the medication hatch and collect her medication.

48. At 2.13pm and 4.35pm, staff found Ms Bailey in the toilet area of her cell, with a ligature tied around her neck. Staff removed the ligatures. The healthcare team attended, but Ms Bailey declined medical treatment. A SO recorded that the second time Ms Bailey had tied two ligatures around her neck and a red friction burn mark was visible.
49. At 5.55pm, staff recorded that they removed another ligature (made from clothing) from around Ms Bailey's neck. The healthcare team examined her but noted she needed no medical treatment.
50. At 6.05pm, a SO, a custodial manager and a wing officer completed an ACCT review after Ms Bailey self-harmed. Ms Bailey did not attend the review and the records give no reason. The SO recorded that staff had removed several ligatures from Ms Bailey that afternoon and although the healthcare team had attended each incident, they considered no medical treatment was needed. He noted Ms Bailey's risk of self-harm as low and her ACCT observations and caremap actions remained the same. Shortly afterwards, staff moved Ms Bailey to another spur and cell on the unit because she alleged that she was being bullied. Staff recorded no further information, and we have seen no evidence to say what happened.
51. At 6.59pm, Ms Bailey phoned her partner. She told him that staff had moved her to another landing because another prisoner had tried to attack her for tobacco. Ms Bailey explained that she would not get her canteen until next week. She asked her partner if he had sent her the paper and stamps she had previously asked him for. He said he intended to do so the next day.
52. At 8.15pm, Ms Bailey again self-harmed in the toilet area of her cell. She tied a ligature made from clothing around her neck. Staff removed the ligature, checked her welfare and considered no medical treatment was needed. Ms Bailey complained about the noise on the unit. This was the twelfth occasion that Ms Bailey had been found with a ligature around her neck.

28 July

53. At around 9.30am, Ms Bailey attended the medication hatch as usual.
54. At 2.00pm and 3.00pm, Officer A attended Ms Bailey's cell and removed a ligature made from clothing from around her neck. The healthcare team examined her but considered she needed no medical treatment despite visible red marks on Ms Bailey's neck. Ms Bailey was upset, said she had no canteen and the noise on the unit was affecting her. The officer was aware of Ms Bailey's impulsiveness and level risk of self-harm from previous periods at Eastwood Park. She felt it was difficult to manage her on a busy unit like Kinnon Unit. She reminded Ms Bailey that she could speak to her at any time by pressing her cell

bell. The officer spoke to the two prisoners, who had been making noise, about their behaviour.

55. At 6.40pm, Officer A attended Ms Bailey's cell and removed a ligature from around her neck. Ms Bailey was compliant and no medical treatment was needed. Ms Bailey told her that she had sold her television to another prisoner for some tobacco and a television that did not work. Ms Bailey now wanted a television that worked. The officer said that tobacco was important to Ms Bailey and she wanted an emergency smoker's pack. (We have seen no evidence that she received a television or a smoker's pack.)
56. At 7.10pm, Officer A removed another ligature from Ms Bailey's neck.
57. At 7.15pm, a SO completed an ACCT case review with Ms Bailey after she had self-harmed that day. He recorded that Ms Bailey's mood was low and repeated that she wanted an emergency smoker's pack. He told Ms Bailey that she did not have enough money for one. He said she should speak to the finance department the next day to transfer money from her private account. He did not change Ms Bailey's level of risk of self-harm, level of observations or caremap actions.
58. Around five minutes later, Officer A checked Ms Bailey and found she had tied a ligature around her neck and attached it to the toilet. The ligature was tight and Ms Bailey was blue in colour and having breathing difficulties. The officer called an emergency code blue and removed the ligature. A nurse responded immediately. When she arrived, Ms Bailey had started to breathe normally, was alert and talking. She examined Ms Bailey. She had a prominent red mark on her neck, but appeared okay. The officer told us that Ms Bailey had made the ligature much tighter than during previous occasions. She had tied it to the toilet, which was novel for her. She told Ms Bailey that such actions were life-threatening. Ms Bailey became angry, and told her to get out of her cell.
59. The scheduled ACCT case review did not take place. The SO said that this was because he was assigned to other duties.

29 July

60. At 8.48am, a prison GP saw Ms Bailey about her alcohol dependency. Ms Bailey was polite, calm and had no tremors. She examined Ms Bailey and said she would switch her to a diazepam detoxification regime for four weeks. Ms Bailey said she was happy in Kinnon Unit.
61. At 9.35am, staff called a code blue emergency after Ms Bailey was found unconscious, with a tight ligature around her neck. The ligature was removed. When the healthcare team arrived, Ms Bailey was breathing but her face was a dusky colour. A nurse administered oxygen until Ms Bailey's normal colour returned. Ms Bailey kept saying "I'm sorry. I needed to stop the voices". The nurse took her observations but considered Ms Bailey did not need medical treatment.
62. Around 4.30pm, wing staff found Ms Bailey in her cell with a ligature made from the elastic of her knickers around her neck. Staff removed the ligature and the healthcare team attended, but no medical treatment was needed.

63. A SO completed an ACCT review with a wing officer and Ms Bailey after she self-harmed. She noted that Ms Bailey had had a good day, despite ligaturing in the morning and afternoon. Ms Bailey had kept herself busy on the unit by cleaning. She noted that she had arranged an emergency smoker's pack for Ms Bailey as she had insufficient funds to buy one. She hoped this would alleviate some of her issues. She increased Ms Bailey's risk of self-harm to raised, but made no changes to her observation levels or caremap actions.
64. At around 8.40pm, Ms Bailey again self-harmed. Officer B found her with a double knotted ligature around her neck. She removed the ligature and Ms Bailey began talking with no difficulties. The healthcare team attended but no medical treatment was needed. Ms Bailey had now ligatured 20 times since her arrival at Eastwood Park.

30 July 2016

65. In the morning, staff issued Ms Bailey with an emergency smokers pack. At 9.25am, Ms Bailey phoned her partner. She told him that she had tried to call him many times the day before but he had not answered his phone. Ms Bailey said that she had not received any canteen and another prisoner on the wing had bought tobacco and coffee for her. She asked her partner to send £10 for this prisoner and he agreed. Ms Bailey gave him the prisoner's name and prisoner number. (The investigator was unable to speak to this prisoner, as she was released from custody soon afterwards.) Ms Bailey said she would call him before 5.00pm. She admitted to him that when she was unable to reach him by phone, she thought he was deliberately ignoring her. It made her feel bad and she self-harmed. Ms Bailey's partner said that he was not ignoring her but was working. He said he loved her and was worried about her. As Ms Bailey's phone credit was low, she asked her partner to send her £50.
66. At 5.06pm, Ms Bailey phoned her partner. They had a general discussion and she asked him if he had sent the £10 to the prisoner, as she had asked. He said no and so Ms Bailey told him not to send it. She asked her partner for some stamps, writing paper and envelopes and £50 again. He agreed to send the stationery and would send the money when he had it.
67. At 7.50pm, staff recorded that Ms Bailey was in good spirits. At 9.00pm, Officer B found Ms Bailey with a very tight ligature around her neck, tied to the toilet seat unconscious. She was blue in colour and panicking because of breathing difficulties. The officer removed the ligature and Ms Bailey started breathing normally. The healthcare team arrived immediately but considered no medical treatment was needed. Ms Bailey apologised to the staff for her actions. Ms Bailey had now ligatured 21 times.

31 July

68. Just after midnight, staff recorded in the ACCT record that Ms Bailey had cut both her wrists with a broken up coke tin can. She handed in the tin but refused medical treatment.
69. In the morning and afternoon, Ms Bailey cleaned the unit. She phoned her partner at 3.21pm and said she might be released early from custody if she had

an address she could use as her place of residence. She asked him if she could use his home address. He refused because of her past behaviour. Ms Bailey pleaded with her partner that she would behave herself. Ms Bailey told him that she had cut her arms the night before and her partner said, "Don't do this to me".

70. At around 6.25pm, staff recorded that they had found Ms Bailey with a ligature around her neck. The ligature was removed and the healthcare team attended. Ms Bailey refused to engage with the nurse.
71. At 8.30pm, a SO completed an ACCT review with a wing officer after Ms Bailey had self-harmed. Ms Bailey did not attend the review but no one recorded a reason. She noted that Ms Bailey had ligatured but gave no reason for self-harming. She increased Ms Bailey's risk of self-harm to high but did not change her ACCT observation level or caremap actions.
72. At 9.00pm, Officer B found Ms Bailey with a tight ligature around her neck. She called a medical emergency code blue and removed the ligature. Healthcare attended and the ambulance was cancelled. No further information was recorded about this incident.
73. At around 11.00pm, Officer B checked Ms Bailey. She was in the toilet area of the cell and was unresponsive when he called her. Concerned, the officer sought permission from the custodial manager, and the night officer in charge of the prison, now resigned from prison service, to enter the cell. She found Ms Bailey with a very tight ligature around her neck and attached it to the toilet. She called a medical emergency code blue and removed the ligature. Ms Bailey started to breathe and slowly began to regain consciousness as the healthcare team arrived. They cancelled the ambulance.
74. The nurse examined Ms Bailey and noted that she had self-harmed by scratching her arms. Ms Bailey told the nurse that she wanted to be alone so that she could kill herself. Although the nurse noted that the officers planned to increase Ms Bailey's ACCT observation level, no changes were made. Ms Bailey had now ligatured 25 times since she arrived at Eastwood Park.

1 August

75. At 11.48am, Ms Bailey phoned her partner. She told him that she did not have much phone credit left. She tried to discuss her release plans again and said she would not get into any trouble. She added that it would also give her the chance to look for her own place to live. Ms Bailey's partner said she could not stay with him. He said Ms Bailey would keep him awake. Ms Bailey pleaded with him and then said that if he could not help her, she would get someone to "smash him up". Her partner ended the call abruptly.
76. Ms Bailey collected her medication as usual. At 4.25pm, staff removed a tight ligature made from clothing from around Ms Bailey's neck which she had tied to the toilet in her cell. The healthcare team attended. A nurse recorded that on his arrival, Ms Bailey was "thrashing around" on the cell floor. She soon calmed down and was moved to her bed where he examined her. Ms Bailey was conscious, alert and had some marks on her neck. Despite this, staff considered that no medical treatment was needed.

77. Afterwards, a SO completed an ACCT review with Ms Bailey. He recorded that staff had removed a ligature from around Ms Bailey's neck. He made no changes to her risk of self-harm (which was high), her observation level (five times an hour) or caremap actions.

2 August

78. At 10.00am, a nurse saw Ms Bailey. Ms Bailey told her that she wanted to see a mental health nurse and wanted medication to help her sleep. The nurse agreed to speak to the doctor about prescribing sleeping medication.
79. An officer told the investigator that he was on duty on Kinnon Unit all day. He described it as a busy unit, as it included the detoxification landing and there were only two members of staff. He said staff tried to keep Ms Bailey out of her cell (doing jobs) as much as they could because she was on a high level of observations and this made it a slightly easier for them to monitor her.
80. At around 1.30pm, Officer C was unable to get a response from Ms Bailey during an ACCT check. He entered the cell and found Ms Bailey in the toilet with a ligature (strips of bedding) tied around her neck. He removed the ligature. When the healthcare team arrived, they noted Ms Bailey was breathing and talking but refused medical treatment. Ms Bailey had now tied ligatures around her neck 27 times since her arrival at Eastwood Park.
81. At 3.00pm, a SO completed an ACCT review with Officer C and Ms Bailey. He recorded that Ms Bailey had self-harmed at lunchtime. Her risk of self-harm, her level of observations and caremap actions remained the same.
82. Ms Bailey spent time in the prison yard between 3.30pm and 4.00pm. From 4.00pm, prison staff locked all prisoners, including Ms Bailey, in their cells. CCTV shows that Officer C checked Ms Bailey at 4.03pm, 4.07pm (when remained at her cell for three minutes) and 4.29pm. On the last occasion, he said Ms Bailey was out of sight in the toilet area. He asked her what she was doing and Ms Bailey said she was using the toilet and was okay. He told her he would be back to check on her in five to ten minutes.
83. At 4.42pm, Officer C returned to check on Ms Bailey. She was still in the toilet area but did not respond when her name was called. He used his radio to notify staff that he was going into Ms Bailey cell. He found Ms Bailey in a seated position, with two ligatures tied around her neck. He immediately cut the ligatures and radioed for medical assistance. He checked Ms Bailey for signs of life. She had no pulse and was not breathing.
84. A nurse and the custodial manager arrived at Ms Bailey's cell in around 30 seconds. The nurse said that the officer had called for medical help but had not used a code blue. She therefore did not bring the medical emergency bag. She said the officer had just removed the ligatures when she arrived. Ms Bailey was slumped face down on the toilet floor. She turned Ms Bailey over. She was blue in colour and she was unresponsive. She and the custodial manager pulled Ms Bailey out of the toilet area and to the cell floor. They checked Ms Bailey for signs of life but found none. The nurse started cardiopulmonary resuscitation and the custodial manager managed Ms Bailey's airway. The nurse asked a

healthcare assistant to call a medical emergency code blue. The control room log recorded a code blue at 4.48pm and an ambulance was immediately called.

85. The nurse responded to the code blue emergency along with another nurse. She brought the medical emergency bag and immediately helped the first nurse. They used medical equipment to maintain Ms Bailey's airway and the first nurse took over chest compressions.
86. Healthcare staff continued cardiopulmonary resuscitation and Ms Bailey was given oxygen through a facial mask. A prison GP arrived and helped. The paramedics arrived at 4.56pm and moved Ms Bailey on to the landing. Shortly afterwards, they detected a pulse and Ms Bailey was taken to hospital in a critical condition. At 10.00am, on Sunday 8 August, Ms Bailey died in hospital.
87. The police found sharp pieces of a broken can and a strip of torn bedding hidden in the cell.

Support for staff and prisoners

88. The Governor debriefed the staff involved in the emergency response and offered her support and that of the staff care team. Staff reviewed prisoners assessed as at risk of suicide and self-harm in case they had been affected by Ms Bailey's actions.

Family liaison

89. Two staff were appointed as the prison's family liaison officers. They contacted Ms Bailey's partner, explained what had happened, and offered support. He visited Ms Bailey in hospital. In line with Prison Service policy, the prison contributed to the costs of Ms Bailey's funeral.

Cause of death

90. A post-mortem examination concluded that Ms Bailey died as a result of hypoxic ischaemic encephalopathy caused by pressure to the neck. As Ms Bailey had been in hospital for seven days before her death, no toxicology tests were undertaken.

Findings

Assessment of Ms Bailey's risk

91. Prison Service instruction (PSI) 64/2011 on safer custody lists a number of risk factors and potential triggers for suicide and self-harm. Ms Bailey had several factors that increased her risk including a history of significant self-harm, substance misuse issues and mental health issues including post-traumatic stress disorder, depression and personality disorder.
92. It is mandatory that staff begin ACCT monitoring after an incident of self-harm. They must set observations at a level appropriate to the risk. PSI 64/2011 says staff should consider constant supervision for the following reasons:
 - Serious attempts and/or compelling preparations for suicide, e.g. making a ligature, hoarding medication and/or writing a suicide note.
 - A credible expression of a wish to die.
 - A recent and credible attempt by a prisoner to take her own life e.g. in prison and before admission to prison.
93. Ms Bailey met these criteria. On 25 July, she told staff that she wanted to kill herself and tied a ligature around her neck. While staff appropriately began suicide and self-harm monitoring, we have seen no evidence that they considered constant supervision. We recognise that five observations an hour is a high level of monitoring, but even when Ms Bailey harmed herself twice more within hours, no one reviewed or increased the frequency of her observations.
94. While we understand that constant supervision should be used only at times of acute crisis, staff should have considered it. The SO who completed Ms Bailey's first ACCT review told us that he knew Ms Bailey from her previous periods in custody. When he saw her on 26 July, he felt that her mood and demeanour had improved, and that the agreed level of observations in Kinnon Unit was appropriate. A nurse confirmed that during previous periods at Eastwood Park, Ms Bailey was monitored under constant supervision. When she saw Ms Bailey on 27 July, she assessed her risk as high but that she was not in crisis, and did not need to move to Unit 4, where staff were resourced to support prisoners under constant supervision.
95. The ACCT process relies on staff using their experience and skills, as well as local and national assessment tools to determine risk. While a prisoner's presentation and history is important and reveals something of their level of risk, it is only one piece of evidence in judging risk. Staff appeared to be swayed by Ms Bailey's improved demeanour compared to their knowledge of her previous periods in custody, despite her continued prolific self-harm. They should have considered ways to heighten their response to her determination to ligature and reviewed options for managing her risk as the seriousness of her use of ligatures became apparent.
96. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm. Objectively, Ms Bailey tied 28 ligatures around her neck between 25 July and 2 August – on every day from

arriving at Eastwood Park until she died. Some ligatures were tight enough for her to experience serious breathing difficulties and lose consciousness – this happened on 28, 29, 30 and 31 July and finally on 2 August. In the days before Ms Bailey’s death, staff noted a marked change in the gravity of her self-harm. She had started tying ligatures to the toilet in her cell. Yet, this did not result in staff noting a change to her risk or altering the frequency of observations. With the benefit of hindsight, we consider that a period of constant supervision was appropriate to ensure Ms Bailey’s safety. We make the following recommendation:

The Governor should ensure that staff fully consider all risk factors when assessing prisoners at risk of suicide and self-harm. Constant supervision should be considered when indicated, in line with guidance in PSI 64/2011.

ACCT procedures

97. PSI 64/2011 requires ACCT case reviews to be multi-disciplinary. No one from the mental health or CARATS team attended Ms Bailey’s first ACCT case review despite staff knowing about her prolific history of self-harm, mental health issues and substance misuse. Ms Bailey’s case manager held only one case review with her on 26 July. No one else attended, and the records indicate that the purpose of it was to introduce himself to her rather than assess her risk.
98. The PSI says that in addition to planned case reviews, where an ACCT trigger event occurs or there are other concerns such as an increase or change in self-harm behaviours, a case review must be held to assess whether another assessment is needed. This did not happen.
99. Staff completed seven ACCT case reviews in response to multiple incidents of self-harm, chaired by six different case managers. This led to inconsistency in approach and prevented identified issues being addressed over time. Primary care nurses attended just two of these reviews, and no one from the mental health team attended any of them. This was unacceptable, particularly in light of Ms Bailey’s mental health history which was well known to the prison. Even when multi-disciplinary attendance is not possible, the PSI says it is critical that ACCT case reviews involve more than one member of staff. Yet, only one member of staff completed two of Ms Bailey’s ad hoc reviews. Staff completed three reviews without Ms Bailey present and recorded no reason for this.
100. PSI 64/2011 requires caremaps to reflect the prisoner’s needs, level of risk and the triggers of their distress. Caremaps should address issues identified in the ACCT assessment and reviews, and consider factors including health interventions, peer support, family contact and access to diversionary activities. Each caremap action must be tailored to meet the individual needs of the prisoner, be aimed at reducing risk and be time bound.
101. At the first case review, a SO recorded Ms Bailey’s issues as her detoxification and referral to the mental health team. The action for referral to the mental health team was noted as completed, as soon as he added it to the caremap. No one assessed if the action had a positive effect on reducing Ms Bailey’s risk of suicide and self-harm. Other issues Ms Bailey raised, such as needing tobacco, were not addressed in the caremap. There was little evidence that staff

discussed her safety at ACCT case reviews or the implications of an allegation that another prisoner had bullied her. Ms Bailey had identified her partner as someone who could support her through ACCT monitoring. Despite this, no one contacted her partner and staff did not identify him as someone who could offer Ms Bailey support. The case manager should review the prisoner's caremap at each case review to ensure that it is still relevant to a prisoner's current needs and risks. Yet there is no evidence that staff revisited or updated the caremap at any point before her death.

102. There is no evidence that the mental health team were involved in any of Ms Bailey's ACCT reviews or that they were consulted. From the available evidence, no one considered alternative methods of reducing Ms Bailey's risk, such as alternative clothing or changing her location to give her additional support. We note that after Ms Bailey's death, the police found sharp pieces of a broken Coke can and strips of torn bedding hidden in her cell. Unlike in Ms Bailey's previous period at Eastwood Park, there was no evidence that staff searched her or her cell to confiscate material that she might use to harm herself.
103. The ACCT guidance gives staff clear indicators about when a prisoner's risk of self-harm is low, raised or high and what action should be taken. For example, the guidance notes that a prisoner would be considered as low risk when suicidal thoughts are fleeting and soon dismissed, and the prisoner has no self-harm behaviour or mental health issues. A prisoner considered to have a raised risk is someone with a history of self-harm, who has frequent but fleeting suicidal ideas and no specific plan or immediate intent. Prisoners should be considered high risk if they have frequent suicidal ideas, evidence of mental health issues, significant alcohol or drug misuse and an escalating pattern of self-harm. It is clear that against these standards, staff should have assessed Ms Bailey's risk of self-harm as high throughout her time at Eastwood Park.
104. At Ms Bailey's first case review, the case manager deemed her risk as low and that she should remain on five observations an hour, which is a high level. This is inconsistent. Despite Ms Bailey's frequent suicidal ideas, serious instances of self harm, mental health issues and significant substance abuse, staff assessed her risk of self-harm as low during five out of nine ACCT reviews. They assessed it as raised once and three times as high. If a risk changes in severity, this must be addressed in the careplan. Yet Ms Bailey's caremap was not updated and we consider that this demonstrates a lack of effective operation by staff of the ACCT procedures.
105. PSI 64/2011 recommends that prisoners at risk of suicide and self-harm are managed under an enhanced case review process in a number of circumstances, including when their self-harm is prolific, as Ms Bailey's clearly was. While it is not mandatory to manage prisoners in this way, staff should have considered this approach for Ms Bailey as it would have involved more specialists in her care, including the mental health team and would have given them a more coherent approach to managing Ms Bailey's risk. Ms Bailey's case manager said he was appointed because of the complexity of her behaviour. Yet, other than his introductory ACCT review after Ms Bailey arrived at Eastwood Park, there were no other scheduled ACCT reviews. With the increasing number of self-harm

incidents and despite a few ad hoc case reviews, this is unacceptable. We make the following recommendation:

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

- **Holding multi-disciplinary ACCT reviews with continuity of case management and involving all staff who can contribute to the care of a prisoner at risk.**
- **Assessing prisoners' risk of self-harm in line with national instructions.**
- **Using the enhanced case review process, when appropriate.**
- **Setting effective caremap objectives which reflect decisions from reviews, are specific and meaningful, and which identify who is responsible for them and when they have been completed.**

Managing Ms Bailey's mental health and staff's response to Ms Bailey's risk

106. When Ms Bailey was at Eastwood Park from February to May 2016, she lived in Unit 4. Prisoners in this unit benefit from the daily support of the mental health team and planned (often enhanced) ACCT reviews. The mental health team saw Ms Bailey only once in Kinnon Unit between 25 July and 2 August. Although she self-harmed 20 times after this contact, the mental health team was not asked to contribute to her care or management of her risk. We do not regard this as acceptable.
107. Most staff interviewed did not consider 27 ligatures in seven days sufficient to transfer Ms Bailey from Kinnon Unit to Unit 4. Yet, some staff admitted during interviews that the same 27 episodes of self-harm in seven days in another case would have alarmed them. They said that Ms Bailey was engaging with them better than during previous sentences and because her early ligatures in this period were not tight, they considered Ms Bailey's risk to be low. They did not take actions open to them to address either the severity or the escalating nature of her self harm.
108. We saw no evidence that staff on Kinnon Unit shared their concerns with staff on Unit 4, who had an extensive knowledge of Ms Bailey's mental health and self-harm history. This included a previous psychiatric evaluation in April 2016 and her medical record, which said that her self-harm could be impulsive and change rapidly. We are concerned that senior staff in Kinnon Unit did not escalate Ms Bailey's ACCT management plan. We share the clinical reviewer's view that while Ms Bailey was well supported from February to May 2016, the same could not be said of her final period in custody. He suggested that this was due to her location in Kinnon Unit, where prisoners had less mental health input and were subject to less robust ACCT procedures than in Unit 4. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison, healthcare and mental health teams share all relevant information to enable accurate ACCT assessments and subsequent risk management of

prisoners at risk of suicide and self-harm to take place, including consideration of the prisoner's location and availability of appropriate interventions.

The wider picture of bullying and drug culture on Kinnon Unit

109. Ms Bailey alleged that she was being bullied by other prisoners on Kinnon Unit and staff moved her to a different location on the unit. There is no evidence that staff thoroughly investigated her allegation or identified the perpetrators. As a result, we cannot conclude whether or not Ms Bailey was bullied or what impact that had on her risk of suicide and self-harm.
110. During investigations into two previous deaths in Kinnon Unit, staff expressed concerns about Kinnon Unit and issues such as tobacco, which lead to bullying. Kinnon Unit has always had a difficult prisoner group because it is the detoxification unit, where many prisoners begin their sentences. The high number of prisoners subject to suicide and self-harm monitoring in Kinnon Unit mean that officers are further stretched and find it hard to monitor prisoners properly and ensure their safety. We understand the concerns raised with us by staff about the challenges such an environment poses to their personal resilience and their welfare.
111. We note that since the last death at Eastwood Park the Governor commissioned an internal review of Kinnon Unit and, in a previous investigation report, we recommended that the Deputy Director of the Women's Estate should oversee this exercise. We would be grateful for an early report on progress, and make the following recommendation:

The Deputy Director of the Women's Estate should provide the Ombudsman with an update on progress about the review of Kinnon Unit within one month of this initial report.

Emergency response

112. PSI 03/2013 on medical emergency codes, says that staff should use an emergency code blue when a prisoner is unconscious. Staff should communicate the nature of a medical emergency and take the correct equipment to the incident to ensure that there are no delays in calling an ambulance.
113. When Officer C found Ms Bailey unconscious, he called for medical assistance rather than an emergency code blue. The first nurses who arrived at Ms Bailey's cell did not know they were attending a life-threatening situation and did not take emergency medical equipment to the cell. As a result, it took at least six minutes for staff to realise the severity of the situation and radio a code blue. The control room then broadcast a code blue and called an ambulance promptly. Resuscitation attempts ensured that Ms Bailey survived and was taken to hospital. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including calling an appropriate emergency medical code immediately when indicated.

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