

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Celeste Craig a prisoner at HMP Styal on 23 October 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.

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

Ms Celeste Craig was found hanged in her cell at HMP Styal on 23 October 2016. She was 26 years old. I offer my condolences to Ms Craig's family and friends.

Ms Craig was a vulnerable, drug abusing young woman who, sadly, said she felt safer in prison than in the community. She had returned to Styal some three weeks prior to her death. During this time, staff missed opportunities to assess her mental health properly. A fuller consideration of her risk of suicide should have taken place before staff decided that suicide and self-harm prevention procedures were not necessary. The investigation also identified that there were some weaknesses in the emergency response.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

July 2017

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Summary

Events

1. Ms Celeste Craig had served numerous short prison sentences at Styal since 2009. She misused a number of drugs and was often homeless in the community. On 11 July 2016, she was sentenced to 20 weeks custody. Six days later, she tied a belt around her neck, attached it to the wing railing and said she was going to jump. She later told staff she had been withdrawing from New Psychoactive Substances, or NPS. Staff began suicide and self harm monitoring procedures (ACCT) which they continued until 2 August when Ms Craig was no longer considered a risk to herself.
2. On 16 September, Ms Craig was released from prison but was later recalled to custody and was returned to Styal on 4 October. Staff observed her smoking what they suspected to be NPS and she was moved to the care and separation unit. She later admitted to NPS use at a disciplinary hearing and was given five days cellular confinement as a punishment.
3. During this time, staff became worried that Ms Craig was behaving bizarrely. They contacted the mental health team and a nurse assessed her. Although Ms Craig seemed paranoid, the nurse had no concerns that she presented a risk to herself and booked her next appointment for six days later. Ms Craig moved back to the wing on 10 October. Prisoners told the investigator she was paranoid, behaving strangely and withdrawing from NPS. On 11 October, an officer contacted the mental health team as she was concerned about Ms Craig's behaviour, but no one was available to assess her at the time.
4. Prisoners told the investigator that they thought that Ms Craig's mood improved over her time on the wing. Ms Craig attended regular appointments with substance misuse workers and disclosed that she was using unprescribed subutex.
5. On 23 October, some prisoners told the investigator that Ms Craig was upset. Staff had no concerns about her, however, and an officer locked her into her cell around 5.00pm. She shouted to another prisoner through the cell wall at around 8.00pm. At 9.30pm, another prisoner asked the Operational Support Grade if he could ask Ms Craig to turn her music down. When he looked through Ms Craig's observation panel, he saw her hanging. He radioed for staff assistance and, 70 seconds later, together with his colleague, unlocked Ms Craig's cell and cut her down.
6. More staff arrived almost immediately and began cardio-pulmonary resuscitation (CPR). A custodial manager asked for an ambulance to be called. Nurses attached a defibrillator to Ms Craig and paramedics took over treatment. Resuscitation efforts were unsuccessful and Ms Craig was pronounced dead at 10.39pm.

Findings

Assessment of risk

7. Ms Craig had a number of risk factors for suicide and we are concerned that these were not considered holistically, particularly in light of her continued drug use and previous behaviour when withdrawing. The investigation also found that not all staff had received ACCT training.

Clinical care

8. The clinical reviewer concluded that Ms Craig's care was not equivalent to that she could have expected to receive in the community, although some aspects were of an acceptable standard. Ms Craig received good substance misuse support and staff appropriately responded to Ms Craig having brought NPS into the prison. However, healthcare staff missed opportunities to fully assess her mental health, despite concerns voiced by prison staff that she was behaving bizarrely and seemed paranoid.

Emergency response

9. When staff found Ms Craig, they did not use an emergency code, thereby delaying the request for an ambulance. Staff took 70 seconds to go into Ms Craig's cell due to staff sharing emergency cell keys and those present obtaining permission to enter Ms Craig's cell.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff working with prisoners have an understanding of risk factors for suicide and self-harm and are vigilant about any changes that might indicate an increased risk.
- The Governor and Head of Healthcare should ensure that:
 - The mental health team assesses all prisoners on the day of their arrival.
 - A dual diagnosis team is established to ensure prisoners with related mental health and substance misuse issues are managed appropriately.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
 - Staff efficiently communicate the nature of a medical emergency using the appropriate code.
 - All night staff carry individual emergency cell keys and enter cells as quickly as possible in a life threatening situation.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Styal informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator visited HMP Styal on 31 October. She obtained copies of relevant extracts from Ms Craig's prison and medical records.
12. The investigator interviewed nine members of staff and three prisoners at HMP Styal in December. She also interviewed five members of staff and four prisoners by telephone. She interviewed a researcher at the PPO office and the clinical reviewer interviewed a further member of staff by telephone. The investigator wrote to a recently released prisoner, but she did not respond.
13. NHS England commissioned a clinical reviewer to review Ms Craig's clinical care at the prison. She conducted some interviews jointly with the investigator.
14. We informed HM Coroner for Cheshire of the investigation. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Ms Craig's mother, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She asked how Ms Craig had managed to hang herself as when she visited Ms Craig's cell there was nothing for her to attach a ligature to.
16. Ms Craig's mother received a copy of the initial report. The solicitor representing Ms Craig's mother wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
17. HM Prison and Probation Service (HMPPS) also received a copy of the report. They accepted all the recommendations. They also pointed out some factual inaccuracies which have been amended accordingly.

Background Information

HMP Styal

18. HMP Styal is a prison in Wilmslow, Cheshire holding up to 460 women. There are a variety of residential units, with 16 separate houses holding about 20 women, and a mother and baby unit. There is also a wing holding up to 134 women where Ms Craig was mainly located.
19. Spectrum Community Health runs healthcare services at the prison. Lifeline delivers psychosocial intervention to substance users. Greater Manchester West Mental Health NHS Foundation Trust provides mental health services. There are nurses on duty at all times with one registered nurse and a health support worker available at night. GP sessions are held every day except Sundays, when there is an out of hours service. There is no in-patient facility.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Styal was conducted in November 2014. Inspectors reported that Styal was a very good prison and they were impressed with efforts to give prisoners responsibility for themselves. They noted that most prisoners felt safe and there were good relationships between staff and prisoners. Prisoners subject to suicide prevention monitoring procedures generally received good support and were offered a wide range of interventions. Most assessments were considered good, well-coordinated and multidisciplinary.
21. Inspectors noted that substance misuse support had improved and was now good overall. The supply reduction action plan had been reviewed to reflect the challenges presented, and proactive steps taken to address these challenges, including trading in prescribed medications. Inspectors reported that the Drug and Alcohol Recovery Service (DARS) delivered an impressive range of psychosocial interventions and prisoners were positive about the support available.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to April 2016, the IMB reported that the mental health team at Styal continued to provide a good service. Prisoners often self-referred to be seen by a mental health nurse, at twice-weekly clinics. Operational staff also assisted this referral process.
23. The IMB noted that drugs were a major concern at Styal. On a few occasions, NPS had entered the prison in significant amounts, but for the most part opiates, opiate-substitutes and cannabis were the substances most usually identified following finds and drug testing. The prison's prime security objective for 2016-17 was to reduce substance use, demand and supply within the prison. They concluded that Styal used good intelligence and observation of women in the first days of their sentence to identify those bringing illegal substances into the prison.

Previous deaths at HMP Styal

24. Since 2011, we have investigated the deaths of five prisoners at Styal, including that of Ms Craig. The other four deaths were all due to natural causes. We have identified an issue in both this, and an earlier investigation, concerning delays in requesting an ambulance in an emergency.

Assessment, Care in Custody and Teamwork

25. 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. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Segregation Units

26. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. The unit at Styal is known as the care and separation unit and comprises nine cells.

Incentives and Earned Privileges (IEP) Scheme

27. Each prison has an Incentives and Earned Privileges (IEP) scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

New Psychoactive Substances (NPS)

28. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened

energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

29. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
30. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

31. Ms Celeste Craig had served numerous short prison sentences since 2009, usually at HMP Styal. She was sometimes homeless in the community and had a history of offending to fund her drug misuse. Prison documentation indicates that she had attempted suicide twice in the community: in 2007 by taking an overdose and in 2014 by jumping off a bridge. She told staff and prisoners that she felt safer and more comfortable in prison than in the community.
32. During the first half of 2016, Ms Craig returned to Styal three times to serve sentences of up to six weeks. She told prison staff that she used drugs including heroin, crack cocaine, benzodiazepines (medicine used to assist sleep) and NPS. She also drank alcohol excessively. On 22 February, Ms Craig said she had thoughts of suicide and staff began ACCT suicide and self-harm prevention procedures. These were closed the next day when Ms Craig was assessed as no longer posing a risk to herself. She told staff she had made the statement due to frustration and did not feel suicidal.
33. Staff and prisoners described Ms Craig as a very likeable prisoner but who did not always conform to the regime. Staff submitted 45 security information reports about her conduct between 2014 and 2016. These were largely related to suspected drug possession and supply in prison, and issues with other prisoners.
34. The investigator was approached by a PhD student, who interviewed Ms Craig twice at Styal, in March and April 2016. She informed the investigator that Ms Craig had told her that she had gender dysphoria and that Ms Craig believed this was partly responsible for her substance misuse issues. There is no evidence that Ms Craig had ever told any staff or prisoners that she identified as a man or how this impacted on her behaviour. We therefore make no further reference to this in the report.
35. On 11 July, Ms Craig was sentenced to 20 weeks custody for theft offences and was taken to Styal. Her conditional release date was 18 September and her sentence expiry date was 27 November. Ms Craig told staff that she had been using crack cocaine, heroin, NPS and diazepam in the community. On 17 July, Ms Craig tied a belt around her neck, attached it to the wing railings, climbed onto the other side of the railing and said she was going to jump. She said she wanted to kill herself as she had nothing to live for. After an hour of negotiations, she climbed back over the railings and was taken to the care and separation unit (CSU). Staff noted that Ms Craig might have been under the influence of NPS and began ACCT monitoring procedures.
36. Ms Craig told staff that she was angry about not receiving adequate medication to minimise her withdrawal symptoms from NPS and wanted methadone or diazepam. Ms Craig said she had wanted to die as she had had enough of going in and out of prison and it was the anniversary of her father committing suicide. She said she had taken an overdose of diazepam on 8 July while in the community and had been hospitalised.
37. Over the next few weeks, Ms Craig engaged with the Drug and Alcohol Recovery Service (DARS) and discussed her use of NPS. On 2 August, staff closed her ACCT and Ms Craig moved back to the general residential wing. Over the

following weeks, after warnings about her behaviour, Ms Craig was reduced to the lowest level of the Incentives and Earned Privileges (IEP) scheme. Staff suspected she was involved in the supply of drugs in the prison, distributing drugs for other prisoners who paid her with small amounts of NPS. On 5 September, Ms Craig told a nurse that she had been taking subutex every two days.

38. On 16 September, Ms Craig was released, subject to licence, the terms of which included attending appointments with her offender manager. She did not attend these appointments and her offender manager applied to have her licence revoked. Ms Craig was recalled to custody and returned to Styal on 4 October. She was due for release on 1 December.
39. Staff observed Ms Craig smoking a green leafy substance in the first night centre. As a result, staff moved her to the CSU with the intention of minimising the distribution of drugs around the prison. Ms Craig was placed on a disciplinary charge (adjudication) because of her behaviour. Ms Craig told a nurse that she had been using heroin, crack cocaine, NPS and diazepam since she was last in prison. The nurse noted that Ms Craig seemed under the influence of NPS and had been homeless since she was last released. A drug test was positive for opiates, cannabinoids (including NPS and cannabis), cocaine and benzodiazepines. Ms Craig did not appear to be suffering any withdrawal symptoms and the nurse referred her to a doctor. Ms Craig said she had no thoughts of suicide and self-harm.
40. At 7.30pm, a prison GP assessed Ms Craig through the observation panel in her cell door as there were insufficient staff available to unlock her. He noted that she had no thoughts of suicide or self-harm, looked well, alert and comfortable. He prescribed her trazodone (an antidepressant). On 5 October, a mental health nurse tried to assess Ms Craig. She was unable to do so, however, due to a lack of staff to unlock Ms Craig or an available room to meet. The same day, Ms Craig attended her disciplinary hearing. She admitted that the substance that she had been smoking was NPS which she had brought into the prison with her. She was given five days cellular confinement.
41. A prisoner told the investigator she had been in a relationship with Ms Craig since June. They had met in Styal. On 5 October, she deliberately got herself moved to the CSU to see Ms Craig. She told the investigator that Ms Craig seemed different when she returned to prison on this occasion. She appeared paranoid and said people were following her.
42. A healthcare assistant from the primary care team assessed Ms Craig twice that day. She noted that Ms Craig did not appear to be suffering any withdrawal symptoms and she told her that she would not be prescribed any further medication for the time being. She noted that Ms Craig was “bright, chatty and singing in her cell”. A DARS worker also saw Ms Craig. They discussed the risks associated with NPS.
43. On 6 October, a nurse assessed Ms Craig twice and noted that she had minimal withdrawal symptoms and did not need any medication to alleviate them. A prison GP assessed Ms Craig on 7 October and prescribed her amitriptyline (an antidepressant).

44. On 8 October, an officer telephoned the mental health team as staff were concerned that Ms Craig was behaving out of character. As a result, a nurse assessed Ms Craig around 11.00am. Ms Craig said that undercover police had been following her in the community. She was tearful and said that, for the first time, she did not trust staff or other prisoners and did not feel safe.
45. When the nurse told Ms Craig that the drugs she had taken might have made her paranoid, Ms Craig did not accept this. Ms Craig told the nurse that she had finished smoking the NPS she brought into Styal three days earlier. After around 20 minutes of discussion, the time came for Ms Craig to return to her cell so the nurse asked whether Ms Craig would like to see her when she moved back to the wing. Ms Craig agreed to this. The nurse said she had no concerns that Ms Craig was a risk to herself and booked her next appointment for 14 October.
46. On 9 October, healthcare staff from the substance misuse team tried to assess Ms Craig twice, but she was erratic and agitated so they were unable to do so. A nurse told the investigator that she was responsible for giving prisoners in the CSU their medication that evening. She could hear Ms Craig in her cell talking to herself, making bizarre statements, shouting and being very erratic. She suspected Ms Craig may have taken NPS and therefore did not give her any medication as she was unsure whether it was safe to do so. (Ms Craig's pupils were dilated.) She explained this to Ms Craig through the observation panel. Ms Craig was unhappy about this and kicked the walls of her cell.
47. On 10 October, Ms Craig's period of cellular confinement ended and she moved to the main residential wing. Her cell sharing risk assessment indicated that she was a high risk to others, due to previous fights with prisoners, so she was located in a single cell.
48. On 11 October, an officer, who had known Ms Craig from working at Styal for several years, noted that she seemed different to normal. She recorded that Ms Craig was paranoid, agitated, said that people were following her and was difficult with staff. She told a nurse that she was concerned about Ms Craig and two other prisoners. The nurse was running a mental health clinic on the wing and so could not assess Ms Craig immediately. The officer telephoned the mental health team and spoke to the mental health team manager. She told him that she had concerns about three prisoners, including Ms Craig, who were acting unusually. The officer told the investigator that after this conversation she was expecting a mental health professional to assess these three prisoners.
49. The mental health team manager noted in Ms Craig's medical record that he told the officer that no one from the mental health team was available at that time. He also noted that he had asked the officer whether DARS had been informed as he suspected drugs might have been involved since there were three prisoners acting unusually. The officer told the investigator that she did not remember him saying that no one was available or suggesting that she contact DARS.
50. The mental health team manager told the clinical reviewer that he telephoned DARS to inform them that someone would be contacting them about three prisoners. There is no record of this occurring. The officer said that if she had been aware that Ms Craig was not going to be assessed by the mental health team, she would have spoken to her supervising officer. The mental health

nurse later went to see Ms Craig, who was sleeping in her cell. The nurse saw Ms Craig on the wing afterwards and asked how she was. Ms Craig replied that she was fine and knew how to access mental health services if she needed them.

51. The officer recorded some of her concerns in the wing observation book and in Ms Craig's computerised record. She did not, though, believe that Ms Craig was a risk to herself. She told the investigator that later on she saw Ms Craig singing in her cell and she seemed much more her "normal" self. Ms Craig missed two appointments with DARS that day then, on 12 October, she walked out of her appointment with a DARS worker.
52. The investigator spoke to several prisoners on the wing. A number of them said that Ms Craig was very obviously paranoid when she returned to the wing and believed that staff at Styal were conspiring against her. Most of the prisoners said that they believed her behaviour was due to withdrawal from NPS. Some noticed that she was sweating and aching and that her emotions were very changeable. However, during her time on the wing, prisoners said that her mood improved and she began to seem more cheerful and less paranoid.
53. On 14 October, Ms Craig failed to attend her appointment with a nurse. She later attended her appointment with her DARS worker, to whom she admitted using illicit subutex. Ms Craig said she had felt suicidal when she returned to prison but had no thoughts of this nature at that time.
54. A prisoner, who had been released from prison, returned on 14 October. Rather than returning to Styal, she went to HMP New Hall. She told the investigator that she had offended so that she could be back with Ms Craig. Letters between the two prisoners indicated that they were concerned about each other remaining faithful, and that they loved and missed each other.
55. On 17 October, a nurse saw Ms Craig walking round the prison and asked her why she had not attended her appointment. The nurse said she seemed happy at the time and was singing with another prisoner. Ms Craig said she felt better and had got her head "out of Spice mode". She was confident that Ms Craig knew how to refer herself to mental health services if she felt it necessary in the future.
56. On 18 October a healthcare assistant (HCA) in the substance misuse team, assessed Ms Craig. Ms Craig said she had been using subutex for the last week and was angry with herself because she would not be considered for a place in rehabilitation as a result. She wanted to stop using subutex. She told Ms Craig that she would ask the doctor to prescribe her medication to minimise her withdrawal symptoms, which a doctor later did.
57. On 20 October around 11.30am, a HCA was working in the doctor's room on the wing. Ms Craig asked her for a plaster for a cut on her hand which she said had happened when she was shredding fabric to make curtain ties. She noted that Ms Craig had a history of making ligatures after her mood changed. She told the investigator that although Ms Craig had seemed preoccupied, she had no concerns that she was a risk to herself. She told a supervising officer, who asked the officer on lunchtime patrol to check on Ms Craig. The supervising officer told the investigator that she did not have sufficient concerns to open an

ACCT. When the officer did check, he said that Ms Craig seemed fine and was sitting on her bed listening to music. The next day the supervising officer saw Ms Craig and asked how she was. She replied that she was fine.

58. The investigator spoke to three other officers, who all said that Ms Craig had seemed her usual self when she returned to the wing. The supervising officer also told the investigator that Ms Craig seemed to be coping with being back in prison, and there were no obvious signs that she was withdrawing from, or using, drugs.

23 October

59. A prisoner who lived in the cell next door to Ms Craig told the investigator that, on 23 October, Ms Craig did not seem her usual self and was upset. Another prisoner also said that Ms Craig did not seem herself and was in a “dark place”. However, by contrast, another prisoner said that Ms Craig did seem her usual self during exercise around 3.45pm.
60. A prisoner told the investigator that they had just come in from exercise when Ms Craig told her that her previous partner, a fellow prisoner, had told her that she still loved her. (They had recently been in a relationship for seven years.) Ms Craig went into the prisoner’s cell, became angry and started shouting. The prisoner said another prisoner was also present. (The investigator was not able to interview this prisoner as she had been released and was of no fixed abode. Another prisoner had also been released and did not respond to the investigator’s letter). Ms Craig then began crying and the prisoner tried to reassure her by talking about Ms Craig’s current relationship. Ms Craig became calmer and the prisoner told the investigator she seemed “more than okay” when she left the cell to be locked in her own cell at around 4.00pm.
61. Staff unlocked prisoners to collect their evening meal at around 5.00pm. A prisoner said that Ms Craig, two other prisoners and herself were all in a prisoner’s room, laughing. She said that Ms Craig seemed very happy. She then went to use the telephone and Ms Craig said good night to her on the way to her cell.
62. The investigator watched CCTV footage taken from 5.00pm onwards that evening. An officer locked Ms Craig in her cell at 5.08pm. It appears from other sources that CCTV timings were 30 minutes behind the correct time, so it was actually 5.38pm. The officer said that Ms Craig said “cheers boss” as he closed the door, and he had no concerns about her. When he returned along the landing to double check he had locked all the doors, he looked into Ms Craig’s cell and saw her dancing and singing.
63. Shortly after they were locked in their cells, Ms Craig shouted to two prisoners to watch a film on television. When this had finished, they shouted to each other that they would see each other in the morning. A prisoner estimated that this was around 7.30-8.00pm.
64. Two Operational Support Grades (OSGs) began their night shift working on the wing at 8.15pm. OSG A collected a sealed pouch containing a cell key for them to share. Just before 9.00pm, the OSGs began the roll check on Y side of the

wing. (Ms Craig lived on X side.) They had nearly completed checking all the cells when the prisoner living next door to Ms Craig pressed her cell bell. This was just before 9.30pm. OSG B went to her door within two minutes and spoke to her through her observation panel. She asked him if he could ask Ms Craig to turn her music down, as it was very loud. He assured her that he would, and closed her observation panel.

65. OSG B immediately looked through the panel in Ms Craig's door. He saw Ms Craig had hanged herself from the window with her feet suspended from the floor. The investigator listened to the radio traffic of the emergency response. At 9.31pm, he radioed for patrol staff to go to the wing "for a ligature" and OSG A reached the cell 45 seconds later. OSG B requested permission to break into OSG A's emergency pouch at 9.32pm, and this was granted by the custodial manager. They unlocked Ms Craig's door, 70 seconds after OSG B had first looked into the cell.
66. Ms Craig had hanged herself by tying a sheet to the top of an open window. OSG B supported Ms Craig's weight and lifted her up while OSG A used his anti-ligature knife to cut the sheet from Ms Craig's neck. They laid Ms Craig on the floor and OSG A checked for a pulse. He thought he felt one, and started to put Ms Craig into the recovery position. At 9.33pm, three officers arrived. Having confirmed there were no signs of life, they began CPR immediately. At 9.35pm, the custodial manager arrived at the cell and requested that control room staff telephone an ambulance. They did so immediately.
67. A nurse and a HCA were on their way to Ms Craig's cell. They had not heard OSG B radioing that there was a ligature before this. The nurse arrived at Ms Craig's cell around 9.37pm and confirmed that Ms Craig displayed no signs of life. Staff continued with CPR and the HCA arrived shortly afterwards with the emergency equipment. The nurse attached the defibrillator which advised not to shock, and staff continued CPR. Paramedics arrived at 9.54pm. They took over treatment but resuscitation efforts were unsuccessful and they pronounced Ms Craig dead at 10.39pm.

Contact with Ms Craig's family

68. On 24 October at 4.00am, the Governor and the Head of Operations went to Ms Craig's mother's address, to inform her of her daughter's death, and offered their condolences and support. The prison contributed to Ms Craig's funeral costs in line with Prison Service Instructions.

Support for prisoners and staff

69. After Ms Craig's death, the Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. A further debrief was held for staff on 31 October. Most staff said they had felt well supported by the prison.
70. On the morning of 24 October, the Governor told some prisoners individually that Ms Craig had died. The prison also posted notices informing other prisoners of Ms Craig's death, offering support. Staff reviewed all prisoners assessed as

being at risk of suicide or self-harm in case they had been adversely affected by Ms Craig's death. The prison held a memorial service for Ms Craig and arranged for balloons to be released at the prison in her memory. All the prisoners the investigator spoke to said that, initially, they had felt well supported by the prison. However, three of these prisoners told the investigator that in the following weeks they would have appreciated further support and an opportunity to talk about Ms Craig.

Post-mortem report

71. We have not yet received the post-mortem report but the preliminary cause of death was recorded as asphyxiation caused by compression of the neck due to hanging. The police indicated that Ms Craig did not test positive for any drugs or alcohol, with only prescribed antidepressants detected in her system.

Findings

Assessment of Ms Craig's risk of suicide and self-harm

72. Ms Craig had a number of risk factors for suicide. She had a history of attempted suicide, her father had committed suicide, she suffered from depression, she had been recalled to prison, she had a lack of social support and misused drugs from which she may have been withdrawing at the time of her death. During her last period in prison, she said she had no thoughts of suicide, other than on one occasion, on 14 October, when she told a substance misuse worker that she had felt suicidal when she had first returned to prison, ten days earlier. Ms Craig was not managed within ACCT procedures the last time she was at Styal.
73. On at least two occasions after Ms Craig returned to Styal, prison staff told the mental health team that they were concerned Ms Craig was behaving differently. Prisoners told the investigator that Ms Craig seemed very paranoid which they thought was due to her withdrawing from NPS. We are concerned about the prevalence of NPS in prisons and the effect it has on the behaviours and health of those taking it, including its association with suicide and self-harm. When, in July, Ms Craig was apparently suffering withdrawal symptoms from NPS, she climbed over the railings with a ligature tied around her neck and said she wanted to kill herself.
74. Staff judgement is fundamental to suicide and self-harm prevention, and relies on their using their experience and skills, as well as local and national assessment tools, to determine risk. We are concerned that in assessing Ms Craig's risk to herself, staff did not consider all the risk factors involved but relied on Ms Craig's demeanour and her assurances that she had no thoughts of this nature. They did not explicitly take into account her past behaviour and current drug misuse. The clinical reviewer concluded that the mental health nurse should have opened an ACCT on 8 October following her assessment of Ms Craig. Although we are not convinced that staff needed to begin ACCT procedures, this is a finely balanced decision that should take account of all the risk factors. We have not seen any evidence that this occurred during Ms Craig's last time in Styal. We are also concerned that not all staff working in Styal had been trained in ACCT suicide and self-harm prevention procedures. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff working with prisoners have an understanding of risk factors for suicide and self-harm and are vigilant about any changes that might indicate an increased risk.

Clinical care

75. The clinical reviewer concluded that the clinical care Ms Craig received was not equivalent to that she could have expected to receive in the community, although she noted that some aspects of her care were of an acceptable standard.

Substance misuse

76. When Ms Craig returned to prison she was not suffering any obvious withdrawal symptoms. Staff suspected she was still using drugs at this point and so decided to observe and monitor her regularly rather than prescribe opiate substitute medication. This was appropriate. Ms Craig regularly met with DARS and disclosed to them her ongoing subutex misuse. DARS staff were unable to disclose this information to other staff due to confidentiality agreements with prisoners. Their aim is to work with prisoners to reduce their substance misuse. We concur with the clinical reviewer's view that substance misuse services were delivered to a good standard.
77. Staff suspected Ms Craig had brought NPS into prison with her. They appropriately segregated her and, the next day, during an adjudication hearing, she admitted she had been smoking NPS. She was given five days cellular confinement as a result. All the prisoners we spoke to said that she had no NPS when she moved to the wing and that she appeared to be withdrawing from the drug. We are satisfied that the prison did all they could to reduce the supply of, and demand for, NPS while also offering Ms Craig appropriate substance misuse treatment.

Mental health

78. The mental health team did not assess Ms Craig on the day she arrived at Styal, as is their policy. The mental health team manager told the clinical reviewer that he had already identified this as an issue. The clinical reviewer noted that the reception screening identified that Ms Craig suffered from depression but failed to include that her recent threatened suicide attempt related to her withdrawal from NPS use.
79. A nurse assessed Ms Craig four days after she arrived at Styal, at the request of prison staff. Ms Craig disclosed that she had been smoking NPS and she concluded that Ms Craig was paranoid but was not a risk to herself. The nurse seemingly did not consider her previous threat of suicide when she was under the influence of NPS. This assessment was terminated early due to staffing issues. She scheduled their next appointment for six days later. The clinical reviewer concluded that, due to Ms Craig's presentation, a further mental health assessment should have been scheduled sooner in order to complete a full assessment.
80. On 11 October, wing staff were concerned that Ms Craig was acting differently to normal and again contacted the mental health team. Mental health staff were not available to assess her at that time although the officer said she was not made aware that this was the case. Ms Craig failed to attend her mental health appointment on 14 October.
81. The clinical reviewer concluded that there were missed opportunities to identify a number of mental health concerns. Ms Craig had a history of attempted suicide and threatened self-harm, was using NPS, had expressed paranoid thoughts and had failed to attend mental health appointments. She indicated that Ms Craig's changeable presentation should have been discussed in multidisciplinary meetings with the mental health and substance misuse teams working together

to ensure any drug-induced psychosis was appropriately and safely managed. To this end, she recommended establishing a dual diagnosis team at Styal including professionals from psychiatry, psychology, social care and substance misuse. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **The mental health team assesses all prisoners on the day of their arrival.**
- **A dual diagnosis team is established to ensure prisoners with related mental health and substance misuse issues are managed appropriately.**

Emergency response

82. Prison Service Instruction (PSI) 03/2013, *Medical emergency response codes*, indicates that the Governor must have a medical emergency response code protocol that ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol gives guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, the protocol and their responsibilities during medical emergencies. Governors are required to have a two code medical emergency response system based on the instruction. Styal uses code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red for when a prisoner is bleeding. The control room should call an ambulance when an emergency code is used.
83. OSG B did not use an emergency code. He radioed for patrol staff to attend the wing “for a ligature”. Prison staff responded immediately. The healthcare staff did not hear this request but heard his request for permission to break the emergency pouch shortly afterwards and they responded. Since the emergency code was not used, this led to a four minute delay in an ambulance being called.
84. OSG B said that the emergency codes, code red and code blue, were not used at Styal. He said staff were expected to radio what had happened or what they could see. Some of the other staff the investigator interviewed were also unclear as to whether emergency codes were used.
85. Instructions about night procedures (PSI 24/2011, *Management and Security of Nights*), and about safer custody (PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from other (Safer Custody)*) are clear that preservation of life takes precedence over the usual arrangements for opening cells. At night, prison staff on wings do not carry standard keys but have a cell key in a sealed pouch for use in such an emergency. Where there appears to be immediate danger to life, prison staff can unlock cells by themselves without the authority of the night manager, subject to a personal risk assessment.
86. The two OSGs on the wing shared a cell key and OSG A held the key that night. He got to Ms Craig’s cell 45 seconds after OSG B had first looked through the observation panel. If both OSGs carried their own key there would have been no delay. It took the OSGs another 25 seconds to unlock Ms Craig’s cell, during

which time they sought permission from the custodial manager to break the emergency pouch. OSG A told the investigator that staff always had to receive this permission. We are concerned that staff are unclear about their responsibilities in an emergency. It is evident that the Governor needs to do more to ensure that staff understand and follow emergency procedures. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **Staff efficiently communicate the nature of a medical emergency using the appropriate code.**
- **All night staff carry individual emergency cell keys and enter cells as quickly as possible in a life threatening situation.**

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