

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Sarah Burke, a prisoner at HMP & YOI Drake Hall on 11 November 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 Sarah Burke was found hanged in her cell at HMP and YOI Drake Hall on 11 November 2016. She was 48 years old. I offer my condolences to Ms Burke's family and friends.

Ms Burke had a long history of alcohol dependence and this was her first time in custody. She was initially sent on remand to HMP Peterborough. When Ms Burke appeared in court in October, court escort staff documented that she had said she intended to kill herself. I am concerned that reception staff at Peterborough did not open suicide prevention arrangements, and instead appear to have placed too much reliance on Ms Burke's presentation, rather than her known risk factors.

I am concerned that staff at Drake Hall failed to support Ms Burke appropriately after she told staff, on two separate occasions, that she was under threat from another prisoner. This was only six days before her death. Finally, I am very concerned that the response by staff to events on 11 November was completely inadequate.

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

May 2017

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Summary

Events

1. On 20 September 2016, Ms Sarah Burke was remanded into custody at HMP Peterborough charged with assault and theft. This was the first time Ms Burke had been in prison. She had a long history of alcohol dependence. She also had a history of high blood pressure and asthma.
2. On 18 October, Ms Burke appeared in court, and was convicted and sentenced to three years in custody. She told court staff that she would kill herself but, on her return to Peterborough, staff failed to act on that information and support Ms Burke under Prison Service suicide and self-harm prevention procedures (known as ACCT).
3. On 3 November, Ms Burke was transferred to HMP & YOI Drake Hall. On both 5 and 6 November, Ms Burke told staff that she had been threatened by another prisoner. No action was taken by staff to support Ms Burke or to address the behaviour of the perpetrator.
4. On 11 November, at 8.45am, staff reported that Ms Burke had failed to attend her education class. At 1.24pm, an officer found Ms Burke hanged in her cell. At 1.28pm, staff entered the cell and began resuscitation until paramedics arrived at 1.41pm. The paramedics pronounced Ms Burke dead at 2.20pm.

Findings

Assessment of risk of suicide and self-harm

5. We found that staff at Peterborough failed to act on Ms Burke's well-documented expression of suicidal intent. We believe Ms Burke should have been managed under ACCT procedures on her return from court.

Management of violence and anti-social behaviour

6. Ms Burke told staff at Drake Hall on two consecutive days that she was being threatened, and named the perpetrator. Ms Burke received none of the support that she should have and no appropriate action was taken against the alleged perpetrator.

Clinical Care

7. Although Ms Burke received a good standard of care, we are concerned by the use of different case management systems, reducing effective oversight of prisoners' clinical history. This meant there was no fully coordinated approach to Ms Burke's care at Drake Hall.

Prisoner wellbeing

8. On the day of Ms Burke's death, prison staff did not correctly follow the local protocol for locating absent prisoners. It was over four hours from the time Ms Burke was reported missing before a thorough search for her was undertaken and there were six missed opportunities to check Ms Burke's room

Emergency response

9. We found that there was a delay of four minutes from the time Ms Burke was found hanged to when staff entered her room, cut her down and began resuscitation. There was a further two-minute delay before an emergency code was called and an ambulance was requested. While this did not affect the outcome for Ms Burke, in future emergencies such a delay could be crucial.

Recommendations

- The Director of Peterborough should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular this should ensure that reception and first night staff:
 - Have a clear understanding of their responsibilities and the need to share all relevant information about risk;
 - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from Person Escort Record forms (PER) and other sources; and
 - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.
- The Governor of Drake Hall should ensure that all prison staff are made aware of and understand the local violence reduction protocol and their responsibilities after an act of violence so that staff:
 - Efficiently and effectively communicate the nature of the act of violence;
 - Support and protect victims;
 - Take appropriate measures against perpetrators to address violent or anti-social behaviour.
- The Head of Healthcare of Drake Hall should ensure all health care providers record all interventions in prisoners' primary medical records so all information is captured, enabling appropriate continuity of care for each prisoner.
- The Governor of Drake Hall should ensure that, when a prisoner is reported missing, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Governor of Drake Hall should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that they:
 - Efficiently and effectively communicate the nature of a medical emergency by using the appropriate emergency code; and
 - Begin resuscitation immediately.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP & YOI Drake Hall informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Drake Hall on 18 November. He obtained copies of relevant extracts from Ms Burke's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Ms Burke's clinical care at the prison.
13. The investigator interviewed one prisoner at HMP Foston Hall on 30 November. He interviewed nine members of staff and three prisoners at Drake Hall, in December. Of those interviews, 11 were jointly conducted with the clinical reviewer. He also interviewed three staff at HMP Peterborough in December.
14. We informed HM Coroner for South Staffordshire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Ms Burke's family, to explain the investigation and to ask whether there were any matters the family wanted the investigation to consider. Ms Burke's family, via their legal representative, wanted to know whether Ms Burke had been bullied, and details of the sequence of events on the day of her death. Ms Burke's family received a copy of the initial report. They did not make any comments.

Background Information

HMP Peterborough

16. HMP Peterborough is privately operated by Sodexo Justice Services. It holds men and women in separate sides of the prison and has 24-hour health care provision. Cambridge and Peterborough NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons last inspected Peterborough in February 2015. They reported that most prisoners felt relatively safe, although those with disabilities and some other minority groups felt less so. Victims of bullying or intimidation received practical support. They also reported that lessons learned from four self-inflicted deaths were being applied effectively. Staff understood and used the systems for monitoring and supporting those at risk of suicide and self-harm well.

Independent Monitoring Board

18. Each prison 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 recently published report for the year to March 2016, the IMB noted an increase in assaults on both staff and prisoners during the reporting year. Analysis by the prison suggested several possible causes: increased population, residents diverted to Peterborough due to overcrowding or security transfers. The IMB commented that prisoners under the influence of New Psychoactive Substances (NPS) had presented a constant challenge to the establishment and staff were working to highlight the dangers of using NPS. In their 2015 report, the IMB highlighted the need for staff compliance with ACCT procedures, particularly in Reception. The IMB noted that by August 2015 all healthcare and reception staff had undergone additional ACCT training.

HMP & YOI Drake Hall

19. Drake Hall is a closed prison which holds just over 300 sentenced women. Accommodation consists of 15 house units with mainly single rooms. Each house unit has a small kitchen, a laundry room and a television lounge. There is also a 25 room open unit outside the prison perimeter. Healthcare services are provided by Care UK.

HM Inspectorate of Prisons

20. The most recent inspection of HMP & YOI Drake Hall was carried out in July 2016. Inspectors found that levels of self-harm were lower than in many other women's prisons and good care was provided to those needing support. Challenges with drug use and illicit alcohol were well managed and security arrangements were appropriate. Inspectors judged Drake Hall a respectful prison with good staff-prisoner relationships at its core. The prison had recently received the 'Enabling Environment' award from the Royal College of Psychiatrists. This is a quality mark for organisations that can demonstrate they

promote good relationships and wellbeing, and Drake Hall was the first prison in England and Wales to receive the award. Inspectors found that one area of major weakness at the prison was health care provision. There were some notable failings, namely evidence of delays in accessing many of the services and several aspects of medications management were deficient.

Independent Monitoring Board

21. 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 annual report to October 2016, the IMB noted that Drake Hall provided a safe and secure environment for prisoners where they are treated with humanity and decency. High professional standards were observed by staff and there are consistently good relationships between staff and prisoners. The prison also upholds a committed and innovative emphasis on preparing women for resettlement and reintegration into the community. This is being achieved by the enabling environment. The creation and management of the Open Unit provided further evidence of a sustained drive by the Governor and staff at all levels to support effective rehabilitation.

Previous deaths at HMP & YOI Drake Hall

22. Ms Burke's was the first self-inflicted death at Drake Hall. There had only been one other death, from natural causes in 2014, since this office began conducting independent investigations in 2004.

Assessment, Care in Custody and Teamwork (ACCT)

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 (*Management of prisons at risk of harm to self, to others and from others (Safer Custody)*).

Key Events

24. On 20 September 2016, Ms Sarah Burke was remanded into custody at HMP Peterborough charged with assault and theft. This was Ms Burke's first time in prison. Ms Burke had a long history of alcohol dependence dating back to 2004. She also had a history of high blood pressure and asthma.
25. On arrival at Peterborough, Ms Burke saw a healthcare assistant, who conducted an initial health screen. She recorded in Ms Burke's medical records that she had a history of hypertension (high blood pressure) and asthma and her doctor in the community had prescribed medication. Ms Burke said that she drank ten cans of strong lager every day. She said she had self-harmed in the past but not for many years. Ms Burke said that she had been "beaten up" before coming into custody. The healthcare assistant recorded that Ms Burke had no thoughts of self-harm or suicide. She referred Ms Burke to be seen by a doctor and requested her records from her doctor in the community.
26. A Prison Custody Officer (PCO) saw Ms Burke to complete the reception documentation. She recorded that this was Ms Burke's first time in custody. Ms Burke said she had self-harmed in 2012 but had no current thoughts of self harm. She asked for a tobacco pack and said she had issues with two sisters who were serving prisoners at Peterborough who were from her home town. The PCO noted that Ms Burke appeared cheerful and chatted with staff and prisoners.
27. A prison doctor saw Ms Burke immediately. He prescribed an alcohol detoxification programme of chlordiazepoxide - 10mg and 5 mg capsules in a reducing regime over 8 days (for alcohol withdrawal), thiamine - 100mg, 1 tablet twice daily (for alcohol withdrawal) and vitamin B compound tablets, 1 tablet twice daily (for vitamin replacement therapy).
28. On 21 September, a PCO saw Ms Burke as her personal officer. Ms Burke said this was her first time in prison and that she had been an alcoholic for many years. She said she had children who were now adults, but they were adopted when they were young and she had no contact with them. Ms Burke said she had a partner and had spoken to him. The PCO recorded that she thoroughly explained the rules and regime to Ms Burke due to her difficulties with reading and writing. She also recorded that Ms Burke seemed vulnerable and, for this reason, staff would "keep an extra eye on her".
29. On 22 September, Peterborough received Ms Burke's community health records which confirmed that she was prescribed ramipril and amlodopine (for high blood pressure) and salbutamol inhaler and a clenil modulite inhaler (for asthma). A prison doctor re-prescribed these medications for Ms Burke.
30. On 28 September, Ms Burke saw a nurse, as she complained of a lump on her neck. Ms Burke said she was bitten by a dog a few days before coming into prison. The nurse recorded that there was a lump and puncture marks on Ms Burke's neck and she referred her to be seen by the doctor.
31. On 30 September, a prison doctor saw Ms Burke as a result of the referral made by the nurse. Ms Burke said she was bitten by a dog and beaten up in the days before she entered prison. The doctor recorded that Ms Burke had three very

small moveable lumps on the left side of her neck. She noted that Ms Burke had successfully completed the alcohol detoxification programme. She prescribed a seven day course of co-amoxiclav (an antibiotic).

32. On 18 October, Ms Burke appeared at Crown Court. During the journey to court a PCO completed a Person Escort Report (PER) and a Suicide and Self-Harm Warning (SSHW) form. These documents are intended to alert staff in all criminal justice agencies who come into contact with a prisoner, about his or her risk of suicide and self-harm. Ms Burke said she thought she would not cope in prison and intended to kill herself. The PCO noted this on the forms. Ms Burke was convicted and sentenced to three years in custody. The escort record and the SSHW form accompanied Ms Burke to Peterborough.
33. A Senior Prison Custody Officer (SPCO) saw Ms Burke when she arrived in reception at 6.40pm. He signed the PER and SSHW forms. He did not open an ACCT document. The Head of Safer Custody told the investigator that the SPCO should have immediately opened an ACCT document as the SSHW form contained Ms Burke's statement that she intended to kill herself.
34. A nurse conducted the health screen when Ms Burke returned from court. She recorded in Ms Burke's medical record that Ms Burke was happy with the outcome of her sentence and had no thoughts of self-harm. She told the investigator that she was the member of healthcare staff on duty in reception. She had not been given, or seen, the SSHW form, and that is why the form had not been signed by a member of healthcare. She said that if she had seen the form she would have signed it and immediately opened an ACCT, if one had not already been opened by prison staff in reception.
35. On 3 November, Ms Burke was transferred to HMP & YOI Drake Hall and was seen by a nurse. The nurse recorded that this was Ms Burke's first time in prison and that she was prescribed amolopine, ramipril, salbutamol and clenil modulite. Ms Burke said she had difficulty with reading and writing but would work to improve this.
36. An officer saw Ms Burke as part of the reception process. She told the investigator that Ms Burke seemed fine and raised no concerns. She said she offered Ms Burke the opportunity of making a phone call but she declined. She explained that the induction unit was all single rooms and prisoners are usually housed on that unit for seven days. She recorded in Ms Burke's prison computer record that the reception paperwork had been completed, that Ms Burke was a cigarette smoker and there were no concerns.
37. A brain injury support worker also saw Ms Burke in reception. She explained to the investigator that she worked for the Disabilities Trust Foundation who had been commissioned by the National Offender Management Service (NOMS - now HM Prison and Probation Service) to provide pilot projects to explore the possible link between brain injury and head trauma with offending behaviour. Ms Burke told her that she suffered a head injury in 2000, and also just before she entered custody. Ms Burke said she had problems with her speech which sometimes made her difficult to understand. Ms Burke said she also found it difficult to concentrate in crowds and large groups of people. The support worker

maintained her own case notes of interventions and did not access Ms Burke's medical record.

38. On 5 November, Ms Burke told an officer that a fellow prisoner had threatened her and said she would attack her. The officer recorded in Ms Burke's prison computer record that she had spoken to the prisoner, who said her grandfather had been in a relationship with Ms Burke, who had been abusive towards him. The officer also recorded that she had told both Ms Burke and the prisoner not to speak to each other and to stay away from one another.
39. On 6 November, Ms Burke told an officer that a prisoner had come onto the induction unit and she felt threatened by her. The officer told the prisoner to stay away from the induction unit and from Ms Burke. She did not record this on any prison documentation.
40. The officer told the investigator that only induction prisoners and the two peer support prisoners are allowed on the induction unit. No other prisoners are allowed there. She said that on 5 November, she should have started a violence reduction investigation form (VRI) and completed a security report. She said she made no record of her dealings with Ms Burke or the prisoner on 6 November.
41. The Head of Security and Operations explained that at Drake Hall, when a prisoner reports that they are being bullied, intimidated, threatened, or any anti-social behaviour towards them, a member of staff should open a VRI form. The form provides the detail of what action staff are required to take. The member of staff completes an immediate action plan within an hour of the VRI being opened and that generates an investigation within 24 hours. The investigation is allocated to a Violence Reduction Officer who, in conducting the investigation, considers any relevant support to be put in place for the victim and any relevant support or action required to address the behaviour of the perpetrator.
42. Prisoners all told the investigator that a prisoner threatened and intimidated Ms Burke. They said this was because of an incident that occurred between this prisoner's grandfather and Ms Burke. They all said that she kept coming onto the induction unit, despite having been told by officers not to. They said that Ms Burke asked them how she could avoid going to lunch because she felt threatened by her.
43. The prisoner said at interview that she had known Ms Burke for 10 to 12 years because of Ms Burke's relationship with her grandfather. She said she saw that Ms Burke had arrived at Drake Hall and spoke to her after a couple of days. She said that she had not threatened Ms Burke. She confirmed that an officer told her to stay away from the induction unit and from Ms Burke. She said "like an idiot I didn't listen". She continued to go onto the induction unit and if Ms Burke saw her, Ms Burke would go into her room and shut the door.
44. On 9 November, the brain injury support worker saw Ms Burke to obtain her consent to view her relevant medical records. She recorded in her case notes that Ms Burke appeared in low mood but there was no immediate cause for concern. Ms Burke said that she was "getting on okay" and kept herself to herself. She also completed four health screening tools: patient health questionnaire – 9 (PHQ-9) (a tool to determine depression); general anxiety

disorder - 7 (GAD-7) (a tool to determine anxiety); alcohol use inventory (AUDIT) (to determine the level of alcohol use); and drug use disorders identification test (DUDIT) to determine drug use. The PHQ-9 indicated that Ms Burke had moderate depression; and the GAD-7 indicated Ms Burke had moderate anxiety. She did not enter any of this into Ms Burke's medical record, nor did she refer Ms Burke for assessment by the mental health team.

45. Ms Burke's prison phone records show that while at Drake Hall she made three calls to her sister, on 4, 5 and 8 November. The investigator listened to these calls and at no point did Ms Burke give any indication that she had thoughts of self-harm or suicide. The call made on 8 November ended with Ms Burke saying that she was going to watch 'EastEnders' and would ring her sister the next day.
46. A prisoner told the investigator that she spoke with Ms Burke on the night of 10 November. Ms Burke told her that another prisoner was intimidating her and she wanted to commit suicide. She said that she did not take Ms Burke's remarks about wanting to commit suicide seriously as Ms Burke appeared to say it as a joke.

Events of 11 November

47. On 11 November, at 8.13am, CCTV footage of the induction unit corridor shows Ms Burke going into her room. Ms Burke does not leave her room again after this.
48. An additional learning support practitioner told the investigator that Ms Burke was expected in her education class but had failed to arrive. He explained that he was responsible for collating all the names of absentees from the various education classes and reporting these to discipline staff. He said he notified the names of the absentees, including Ms Burke, at 8.45am.
49. An officer said she was working in the induction unit office that morning organising prisoner moves from the induction unit to other residential units. She said that a prisoner was on the induction unit and she told her to go away. The prisoner left but returned a short time later and she told her to go or she would be placed on report.
50. The prisoner told the investigator that she should have been at work in the gardens that morning but was on the induction unit instead. She said she had collected her tools and had them with her on the unit. She said she ignored what the officer had instructed her to do and knew that she would be in trouble.
51. The additional learning support practitioner explained to the investigator that once prisoners have been reported as absent from the workshops or education, patrol staff search for those individuals. If the patrol staff are unable to find them after approximately an hour, the matter should be escalated to a senior member of staff. Extra staff then search all the residential areas. If a prisoner is still missing, then a stand fast roll check should take place. This is a physical head count of all prisoners in the establishment. If a prisoner still cannot be found, she is declared a missing person.
52. The CCTV footage of the induction unit shows that an officer went to the door of Ms Burke's room and looked through the observation panel at 10.24am, 11.00am

and 11.15am. At 11.38am, another officer arrived at Ms Burke's room and also looked through the observation panel. At 12.10pm, a supervising officer (SO) arrived at Ms Burke's room and looked through the observation panel. At 12.55pm, an officer arrived at Ms Burke's room and he looked through the observation panel. At no point did any member of staff open Ms Burke's door and enter the room. At the roll check of prisoners in the dining hall, Ms Burke was the only prisoner unaccounted for.

53. The Duty Governor that day said that at 1.10pm he was told that Ms Burke remained unaccounted for. He requested all staff to do a physical check of all the units, in every room and to check under the beds and cupboard space.
54. At 1.15pm, the CCTV footage shows a number of prisoners outside Ms Burke's room and looking in through the observation panel. No staff are observed on the unit at this time.
55. Two officers were detailed to check the rooms on the induction unit. At 1.24pm, an officer went into Ms Burke's room and found her hanging in the wardrobe by a ligature made from shoe laces. She came out of the room in a distressed state and told her colleague what she had found.
56. An officer told the investigator that she thought her colleague was going to faint. She went into Ms Burke's room, saw her in the wardrobe, left the room and locked the door. She radioed for urgent assistance but did not give the code blue emergency call, which indicates someone is having difficulty breathing or not breathing. She told the investigator she knew she needed to use an emergency code when someone is found not breathing but was shocked at finding Ms Burke hanging, and simply called for urgent assistance. The control room log shows the message was radioed at 1.25pm. She said she took her colleague to the unit office and they remained there. Prisoners congregated outside Ms Burke's room.
57. At 1.26pm, two SOs arrived on the unit and returned the prisoners to their rooms. At 1.28pm, a custodial manager arrived on the unit and she and a SO entered Ms Burke's room. They immediately cut the ligature, placed Ms Burke on the floor and began cardiopulmonary resuscitation (CPR). The other SO radioed a code blue. The control room log shows the code blue was called at 1.30pm, and the control room staff called an ambulance immediately.
58. A nurse and a healthcare assistant responded to the code blue. They took over the CPR and used an automated external defibrillator (which administers electrical shocks to restore a normal rhythm). The defibrillator found no shockable rhythm, so they continued with CPR. Paramedics arrived at 1.41pm and took over Ms Burke's care. At 2.20pm, the paramedics pronounced Ms Burke dead.
59. Staff found two notes that Ms Burke had written to her sister. In one, she said that a girl was "out to get her", she was scared and she did not want to go for her dinner. In the other, she said if "anything happens to me carry on".

Contact with Ms Burke's family

60. The Governor and the appointed family liaison officer visited Ms Burke's sister at her home, at 5.20pm. They broke the news of Ms Burke's death and offered

their condolences and support. In the days that followed, the family liaison officer maintained contact with Ms Burke's family and, in line with Prison Service guidance, the prison contributed to the costs of the funeral.

Support for prisoners and staff

61. After Ms Burke's death, a manager held a debrief for the staff involved in the emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.
62. The prison posted notices informing staff and prisoners of Ms Burke's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by the death.

Post-mortem report

63. A post-mortem examination, conducted by a Home Office Forensic Pathologist, confirmed that the cause of Ms Burke's death was cerebral anoxia due to hanging. He noted that the toxicology results found no evidence of alcohol or any illicit drugs.

Findings

Assessment of risk of suicide and self harm

64. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include first time in custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.
65. We have considered whether staff should have monitored Ms Burke under the ACCT process when she arrived at Peterborough. When Ms Burke arrived at Peterborough on 20 September, reception staff did not fully assess her risk of suicide and self-harm and did not take any action to support her. Ms Burke had a number of factors known to increase the risk of suicide and self-harm which are identified in our thematic report about risk factors in self-inflicted deaths published in April 2014, and in Prison Service instructions. It was her first time in prison, she had an extensive history of alcohol abuse and was charged with a violent offence. Although we do not know whether this would have affected the outcome for Ms Burke, the failure to open an ACCT meant that she did not receive structured, ongoing support.
66. In the thematic report, we also identified that, too often, assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour.
67. PSI 07/2015, *Early Days in Custody*, sets out mandatory reception procedures and requires reception staff to examine the PER form that must accompany each new prisoner, and any other available documentation. This is: "...to identify any immediate needs and risks already recorded". In addition, PSI 64/2011, specifically states the following mandatory action:
- "Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form"*
68. We are most concerned that an ACCT was not opened on 18 October, when Ms Burke returned to Peterborough from court. The SPCO and the reception officers did not assess her risk of suicide and self-harm and took no action based on the SSHW form. A nurse did not see the SSHW form and, in assessing Ms Burke's risk of self-harm, relied solely on her statement that she had no thoughts of self harm or suicide at that time and did not consider her risk factors when assessing her.

69. According to national mandatory instructions, an ACCT should have been opened on 18 October because of Ms Burke's stated intent to end her life, in addition to other known risk factors. We cannot know whether being on an ACCT would have affected events a month later, but it meant that she did not receive structured, ongoing support.

70. We make the following recommendation:

The Director of Peterborough should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular this should ensure that reception and first night staff:

- **Have a clear understanding of their responsibilities and the need to share all relevant information about risk;**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from Person Escort Record forms (PER) and other sources; and**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

Management of violence and anti-social behaviour.

71. Guidance on the effective management of violent prisoners is contained in PSI 64/2011. The national instruction states "*Every verbal or physical act of violence must be challenged. Appropriate sanctions for perpetrators must be applied robustly, in a fair and consistent manner. Victims must be supported and protected*". Drake Hall has a local protocol for violence reduction and anti-social behaviour which sets out clear steps staff are required to follow to support victims of violence, and the actions to be taken to address a perpetrator's behaviour.

72. An officer was fully aware of the prison's policies and protocols. She failed to instigate a violence reduction investigation on two consecutive days when Ms Burke reported that she was being threatened by a prisoner.

73. Evidence gathered for this investigation has clearly established that Ms Burke was threatened and intimidated by a prisoner, that Ms Burke reported this directly to staff and the prisoner continued to visit the induction unit despite formal instruction from staff to stay away.

74. We consider that Ms Burke did not receive the support from staff that she should have after she reported she was under threat, and no appropriate action was taken to address this prisoner's behaviour. This is a significant failing. We make the following recommendation:

The Governor of Drake Hall should ensure that all prison staff are made aware of and understand the local violence reduction protocol and their responsibilities after an act of violence so that staff:

- **Efficiently and effectively communicate the nature of the act of violence;**

- **Support and protect victims; and**
- **Take appropriate measures against perpetrators to address violent or anti-social behaviour.**

Clinical Care

75. The clinical reviewer judged that overall the care that Ms Burke received from healthcare staff at Drake Hall was equivalent to the care she would have received in the community.
76. The clinical reviewer commented that the Disabilities Trust Foundation either did not record entries, or make retrospective entries on a prisoner's electronic medical record. This meant that Ms Burke's records were not, in effect, correctly maintained as there was little opportunity for comprehensive oversight of her full clinical history and therefore no coordinated approach to her care by all health providers at Drake Hall. Although no actual failing arose in respect of Ms Burke's care, Drake Hall's record-keeping does not comply with General Medical Council and Nursing and Midwifery Council standards. We concur with his comments and make the following recommendation:

The Head of Healthcare of Drake Hall should ensure all health care providers record all interventions in prisoners' primary medical records so all information is documented enabling appropriate continuity of care for each prisoner.

Prisoner wellbeing

77. We are concerned about the prison's response to Ms Burke being reported missing on 11 November. Ms Burke was correctly reported missing by 8.45am. CCTV footage confirms that between 8.45am and 1.00pm, staff went to Ms Burke's room on six separate occasions. However, at no time did anyone open the door and enter the room.
78. Drake Hall does have a local protocol which staff are required to follow when a prisoner is unaccounted for. This is all the more important given Drake Hall's open environment regime. The additional learning support practitioner confirmed that after one hour a full search of all residential units should take place and, if the prisoner has still not been found, a stand fast roll check should be conducted. On the morning of 11 November, the decision to do a full search was not taken until 1.10pm, over four hours after Ms Burke had initially been reported missing.
79. Before the full search was instigated, staff missed six opportunities to check on Ms Burke's wellbeing. It is impossible to know whether this would have changed the outcome for Ms Burke, but the implications for other cases are clear. We make the following recommendation:

The Governor of Drake Hall should ensure that, when a prisoner is reported missing, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Emergency response

80. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant 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, this instruction and their responsibilities during medical emergencies.
81. This national instruction required prisons to have a two-level code system, which differentiates between a blood injury and all other injuries – usually code red - and code blue. Drake Hall's local protocol states the control room should call an ambulance automatically as soon as any emergency code is radioed.
82. When Ms Burke was found two officers neither used an emergency code. From the time that Ms Burke was found hanging there was a delay of four minutes before staff entered the cell, cut Ms Burke down and started CPR, and a further two-minute delay before an ambulance was called.
83. While these issues did not impact on the outcome for Ms Burke, it is important that prison staff understand their roles in a medical emergency, as early intervention when someone is found hanging can save lives. 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 that they:

- **Efficiently and effectively communicate the nature of a medical emergency by using an appropriate emergency code; and**
- **Start resuscitation immediately.**

**Prisons &
Probation**

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