

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Jessica Whitchurch a prisoner at HMP Eastwood Park on 20 May 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 Jessica Whitchurch was found unconscious with two ligatures around her neck in her cell at HMP Eastwood Park on 18 May 2016. She died in hospital on 20 May. She was 31 years old. I offer my condolences to Ms Whitchurch's family and friends.

Overall, I am satisfied that Ms Whitchurch received some good care at Eastwood Park. However, although Ms Whitchurch had tied another ligature less than an hour before she was found unconscious, staff who knew Ms Whitchurch well did not think she was at imminent risk of suicide. They appropriately began suicide and self-harm monitoring, and placed Ms Whitchurch under two checks an hour. I recognise that the judgements required in these procedures are difficult but, with hindsight, I believe an objective assessment of Ms Whitchurch's risk factors in line with published policy justified a period of constant supervision.

More generally, I am concerned that while staff tried to manage the overt bullying of Ms Whitchurch, the underlying culture of bullying on her unit appears to have been pervasive and the options available to staff to support her were limited. Similar issues have arisen in a previous death on the unit and, while I understand that the Governor has commissioned an internal review, I consider that the Deputy Director for the Women's Estate needs to assure himself that the broader implications for safety at Eastwood Park, and even beyond, have been fully addressed.

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

February 2017

Contents

Summary	1
The Investigation Process	4
Background Information	5
Key Events	7
Findings.....	16

Summary

Events

1. Ms Jessica Whitchurch had a complex social anxiety disorder (a personality disorder). She had a history of substance misuse and had served previous sentences at Eastwood Park. She was frequently monitored under suicide and self-harm prevention procedures after incidents of relatively minor self-harm.
2. On 7 September 2015, Ms Whitchurch was remanded to HMP Eastwood Park for attempted robbery, battery and damage to property. She was involved in many incidents with staff and prisoners. She faced disciplinary hearings for fighting, being abusive and violent to staff and diverting her medication. She was frequently managed using the Incentives and Earned Privileges (IEP) scheme. Ms Whitchurch lived in Kinnon Unit, the unit for prisoners detoxifying from drugs and alcohol.
3. In February 2016, Ms Whitchurch, was accepted as an outreach patient by the Nexus personality disorder service in Unit 10. She attended weekly counselling sessions and group work. Ms Whitchurch applied to move to Unit 10 but was refused a place in April 2016. She was upset but continued to access the service.
4. On 6 March, after she argued with another prisoner about drugs, Ms Whitchurch was moved from A spur to B spur. On 14 March, some prisoners from A spur wore strips of her torn clothing and banged on the doors between the two spurs when she went to the servery. An officer investigated and discovered a campaign of bullying against Ms Whitchurch led by the prisoner she had argued with. Other prisoners then alleged that Ms Whitchurch had sexually assaulted and harassed them.
5. On 12 May, Ms Whitchurch tied a dressing gown cord around her neck after someone stole from her. She said she had self-harmed out of frustration and had not intended to kill herself. Staff monitored her risk of suicide and self-harm but stopped monitoring her on 17 May as Ms Whitchurch appeared more positive.
6. Just after noon on 18 May, Ms Whitchurch fought with another prisoner. About 20 minutes later, she was found crying, with some wool tied around her neck. Staff spoke to her for almost ten minutes, restarted suicide and self-harm monitoring and lunchtime patrol officers were instructed to check her twice an hour. Healthcare staff examined Ms Whitchurch at 12.40pm, and were satisfied she was fine.
7. An officer checked Ms Whitchurch at 12.58pm, and called out that she was fine. At the next check at 1.28pm, Ms Whitchurch was found unconscious on her cell floor with two ligatures around her neck. Officers and nurses performed cardiopulmonary resuscitation until paramedics arrived. Ms Whitchurch was taken to hospital by ambulance but died on 20 May.
8. Staff and prisoners reported that the other prisoners on the spur shouted abuse at Ms Whitchurch after the fight and during the lunchtime patrol state. Security intelligence reports received after she was taken to hospital said that Ms

Whitchurch had been bullied by a particular prisoner on her spur and was in debt over illicit drugs.

Findings

9. Overall, Ms Whitchurch's care at Eastwood Park was good. She was referred appropriately to mental health and substance misuse services and the Nexus personality disorder programme. She undertook alcohol and methadone detoxification in line with healthcare policies. Ms Whitchurch applied to move to Unit 10 but a risk assessment raised issues about her suitability. Staff reasonably decided that she was not suitable.
10. Ms Whitchurch was the victim of an orchestrated campaign of bullying on A spur of Kinnon Unit. This was appropriately investigated and sanctions applied to the perpetrators. Ms Whitchurch was supported appropriately by staff. Ms Whitchurch had issues with another prisoner on B spur. Their relationship was not straightforward and there were no obvious signs that Ms Whitchurch was a victim of bullying or vulnerable on B spur.
11. On 18 May, Ms Whitchurch was involved in a fight and other prisoners on B spur verbally abused her at lunchtime. Staff restarted suicide and self-harm monitoring appropriately and used their knowledge of Ms Whitchurch to set observations for her at twice an hour. With hindsight, an objective assessment of her risk factors justified constant supervision.
12. Some aspects of the way ACCT procedures operated were poor. Healthcare staff did not attend first case reviews as required. Reviews were not sufficiently multidisciplinary and, on one occasion, monitoring stopped before one of the identified risk factors had been dealt with.
13. We are very concerned about the wider picture of drug abuse and trafficking and bullying in the prison and especially on Kinnon Unit. Moreover, the current configuration of services at the prison appears to constrain the options available to manage prisoners on the Unit. It is not clear, for example, where else in the prison prisoners who are detoxifying, but who also may be involved in bullying, can be located. We understand that the Governor has commissioned an internal review of the Unit but, given the wider implications, potentially beyond the prison itself, we recommend that the Deputy Director of the Woman's Estate oversees this exercise.

Recommendations

- **The Governor should ensure that staff fully consider all risk factors when assessing the risk of 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 should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:**

- **Staff should hold multi-disciplinary case reviews attended by all relevant people involved in a prisoner's care. A member of healthcare staff should attend all first case reviews.**
- **Care managers should set ACCT caremap actions and review progress against caremaps at each review and not close ACCT plans until all caremap actions have been completed.**
- **ACCT plans should remain on the wing until completion of the post-closure interview.**
- **The Deputy Director of Custody for the Women's Estate should oversee a review of Kinnon Unit and ensure that the range of risks and needs of all women at Eastwood Park can be appropriately addressed.**

The Investigation Process

14. 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. One prisoner contacted her and was interviewed.
15. The investigator obtained copies of relevant extracts from Ms Whitchurch's prison and medical records and CCTV from 18 May 2016.
16. NHS England commissioned a clinical reviewer to review Ms Whitchurch's clinical care at the prison.
17. The investigator interviewed 12 members of staff and four prisoners at Eastwood Park during July and August 2016. The clinical reviewer joined her for four of the interviews. She spoke to one other member of staff by telephone.
18. We informed HM Coroner for Bristol of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers contacted Ms Whitchurch's sister, to explain the investigation. Ms Whitchurch's sister did not have any specific questions she wanted us to consider.

Background Information

HMP Eastwood Park

20. HMP Eastwood Park is a closed women's prison, serving the courts of the South West, Wales and the West Midlands. Bristol Community Health and Avon and Wiltshire Partnership Trust provide primary care, mental health care and substance misuse services.

HM Inspectorate of Prisons

21. The last inspection of HMP Eastwood Park was in November 2013. Another is in progress at the time of writing. In 2013, inspectors reported that relationships between staff and prisoners were particularly strong and most women felt safe. A range of measures to address bullying and violence was in place and a new programme to provide formal support for victims was planned. Security procedures were proportionate and the security department worked well with other departments and agencies. The number of positive tests in mandatory drug tests was very low. Eastwood Park had not logged intelligence-led searches and drug tests requested as a result of security information. This meant that the prison was not able to determine whether they had taken place. The main concern for security was the smuggling of drugs into the prison. Some prisoners said that medication was being traded but inspectors found no evidence that this was a substantial problem.

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 October 2015, the IMB reported that in general, despite staffing constraints, the prison was a safe, secure and decent environment. Their main concern was the increasing number of self-harm incidents and a lack of detailed analysis of the reasons for it. Delays in completing the refurbishment of two of the wings had affected the regime. Despite efforts, staff struggled to control the number of illicit prescription drugs, especially subutex.

Previous deaths at HMP Eastwood Park

23. Ms Whitchurch was the second prisoner at Eastwood Park to take her life in May 2016. In our investigation into the first death, we found evidence of drug culture and bullying but we did not conclude that the death was predictable or preventable. Those issues are also present in this investigation. These were the first apparently self-inflicted deaths at Eastwood Park since 2007. Another prisoner took her life in August 2016.

Assessment, Care in Custody and Teamwork

24. 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.

25. 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (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.
26. 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.

Violence prevention procedures

27. Guidance on violence prevention procedures is set out in PSI 64/2011. The National Offender Management Service operates a zero tolerance policy towards violence, whether physical, emotional or verbal. Staff are required to challenge all forms of violence and appropriate sanctions for perpetrators must be applied robustly. Sanctions include using the incentives and earned privileges scheme, adjudication process and referral to the police. Victims must be supported and protected. Every prison must have its own violence prevention strategy.

The Nexus Personality Disorder Service

28. Nexus is designed to provide a service for women prisoners who present a high risk of reoffending and who have personality problems. The nationally agreed entry criteria for women on the Personality Disorder (PD) pathway is:
 - Current offence of violence against the person, criminal damage, sexual offences and/or offences against children; and
 - Assessed as presenting a high risk of committing an offence from the above categories; and
 - Likely to have a severe form of personality disorder; and
 - A clinically justifiable link between the above.
29. There are 30 places at Eastwood Park, of which 16 are residential on Unit 10. The programme includes psycho-educational and therapeutic groups and individual therapy.

Key Events

30. On 7 September 2015, Ms Jessica Whitchurch was remanded to Eastwood Park, charged with attempted robbery, battery and damage to property. Ms Whitchurch had served a number of prison sentences at Eastwood Park. Ms Whitchurch had a history of substance misuse, self-harm and assaulting other prisoners and staff. Ms Whitchurch had a complex social anxiety disorder (a personality disorder).

September 2015 – February 2016

31. At an initial health assessment, Ms Whitchurch tested positive for buprenorphine, heroin and cocaine. She said that she had been drinking heavily and taking drugs. Ms Whitchurch began a methadone maintenance programme and then completed the alcohol detoxification in line with the prison substance misuse guidelines. She completed a methadone detoxification in January 2016 and was prescribed sertraline, an antidepressant, for anxiety. Ms Whitchurch lived on Kinnon Unit, the unit for prisoners detoxifying from drugs and alcohol.
32. A prison G referred Ms Whitchurch to the mental health team and she was monitored regularly between September and December 2015. Ms Whitchurch attended several psycho-educational groups run by the Substance Misuse Psychosocial Team (SMPT).
33. On 6 October, Ms Whitchurch drank another prisoner's methadone. A prison GP decided not to give Ms Whitchurch her dose of methadone for two days because of the risk of overdose. Staff began ACCT procedures after she then threatened to hang herself. Monitoring appears to have ended on 23 October.
34. On 16 October, an officer found a concealed amitriptyline tablet when she checked Ms Whitchurch's mouth after evening medication. Ms Whitchurch abused and threatened the officer when she placed her on a disciplinary charge.
35. On 19 October, a prisoner said Ms Whitchurch was one of several prisoners being put under pressure to give her medication to someone else. One prisoner was transferred from Eastwood Park after an investigation under violence prevention procedures.
36. On 2 November, Ms Whitchurch was involved in two incidents with another prisoner, who said Ms Whitchurch had attacked her when she refused to give Ms Whitchurch her medication. An investigation under violence prevention procedures took place but was inconclusive.
37. On 14 November, Ms Whitchurch told a nurse that she had bought illicit mirtazapine, an antidepressant, on her unit. On 20 November, she was placed on a disciplinary charge for throwing a fish-filled sock into another prisoner's cell and on 23 November, was removed from the Inside Recovery Programme (a group run by the substance misuse team). When a substance misuse worker tried to explain the reasons for removing her, Ms Whitchurch was abusive.
38. In December 2015, Ms Whitchurch began attending the emotional coping skills group and was noted to have marked difficulty with anxiety and anger. On 10 December, another prisoner alleged Ms Whitchurch was bullying and stealing

from her. On 14 December, a teacher suspected Ms Whitchurch was involved in passing drugs during her class. On 23 and 29 December, Ms Whitchurch was abusive to an officer and canteen staff. On 4 January 2016, she was placed on a disciplinary charge for throwing a cup of tea over a prisoner.

39. On 11 January, an officer began ACCT procedures after Ms Whitchurch made cuts to her neck with a razor. She told a nurse that she struggled with anxiety. An officer assessed Ms Whitchurch the next day; she was tearful and said her self-harm had been a genuine suicide attempt. Ms Whitchurch saw a mental health nurse and the GP within 24 hours. ACCT monitoring ended on 2 February after consistently positive reports about Ms Whitchurch's mood
40. On 18 January, Ms Whitchurch threatened another prisoner who she said owed her tobacco. She was placed on basic IEP regime for a week and threatened an officer when she tried to explain why her television had been removed. Ms Whitchurch was removed from her education course and the activities board decided on 25 January, that she was not suitable to attend courses away from Kinnon Unit. The same day, the consultant forensic psychiatrist agreed with Ms Whitchurch that she would benefit from the Nexus personality disorder programme.
41. On 27 January, Ms Whitchurch was sentenced to 22 months in prison and, on 29 January, she was referred to be assessed for the Nexus programme. On 9 February, Ms Whitchurch began an extended psychological assessment as a Nexus outreach patient; to facilitate this the activities board decision that Ms Whitchurch should stay on Kinnon Unit was over-ridden.
42. Ms Whitchurch received weekly individual psychological therapy. Her treatment plan included dialectical behaviour therapy (a psychotherapy developed to treat borderline personality disorder), Stop and Think (group work to address negative thinking styles), Infobuzz (a social and creative group) and Read and Relax. A worker said she worked with Ms Whitchurch for six weeks in June and July 2015 on her previous sentence. She said Ms Whitchurch was keen to resume their work and attended their sessions.
43. On 10 February, Ms Whitchurch had a fight with a prisoner and was put on basic IEP regime. She threw her television at staff when they went to remove it. Ms Whitchurch was placed on a disciplinary charge. Intelligence was later received that the fight (which also involved another prisoner involved in running drugs and bullying) had occurred because Ms Whitchurch had been given crushed paracetamol instead of subutex (a drug used to treat opiate addiction).
44. On 16 February, an officer began ACCT procedures after Ms Whitchurch made cuts to her leg with a razor. The officer said she was upset about "problems" on A spur. A Supervising Officer (SO) authorised an immediate cell change to an area of the spur where Ms Whitchurch said she felt safe. Ms Whitchurch said that another prisoner was intimidating several women to buy her tobacco. She said she was fed up with being bullied and witnessing other prisoners being bullied. She told the officer at her assessment the next day that her issues had been resolved by moving cells. ACCT procedures were closed.

45. On 19 February, the prisoner who had been attacked on 10 February threw a cup of coffee over Ms Whitchurch. On 22 February, Ms Whitchurch argued with another prisoner in the library.
46. Ms Whitchurch applied to move to Unit 10 as a resident. The extensive risk assessment process took several weeks and included reviewing security intelligence and consulting Kinnon Unit staff about Ms Whitchurch's record of problematic behaviour. During the risk assessment, historic information about allegations Ms Whitchurch had made about her relationship with a Unit 10 officer came to light. In 2013, Ms Whitchurch told other prisoners that she had been in a relationship with this officer. The allegations were investigated by the prison's corruption prevention unit but there was no evidence to prove or disprove them.

March 2016

47. On 6 March, Ms Whitchurch argued with the other prisoner involved in the attack on 10 February who was identified by other prisoners as the main bully and drug supplier on Kinnon Unit. Ms Whitchurch later told staff the argument was about the price the other prisoner charged for drugs.
48. Ms Whitchurch then cut her arms and staff began ACCT monitoring. Ms Whitchurch was moved immediately to B spur. The next day, she told an officer at an assessment that the other prisoner made her feel threatened and she had self-harmed to relieve stress. ACCT monitoring ended shortly afterwards at the first case review because the issue was considered resolved by Ms Whitchurch's move to a new spur.
49. On 10 March, Ms Whitchurch told the psychiatrist that she was finding it hard to manage her relationship with the prisoner that she had argued with. She said the prisoner bullied her and encouraged other prisoners to join in. Ms Whitchurch said this triggered distressing memories of school bullying.
50. On 11 March, a prisoner complained that Ms Whitchurch had made homophobic bullying comments to her. On 13 March, Ms Whitchurch was accused by a prisoner due for release of shredding all of her clothes and shoes. On 14 March, another prisoner (apparently in a relationship with the woman whose clothes had been shredded) threatened Ms Whitchurch.
51. That day, an officer said eight prisoners, including the prisoner Ms Whitchurch argued with on 6 March, lined up and banged the window between A and B spur when Ms Whitchurch collected her lunch. They were all wearing torn pieces of a pair of Ms Whitchurch's trousers. The officer investigated the incident under violence prevention procedures, interviewed the prisoners and took statements. Ms Whitchurch said she was the victim of a campaign of bullying orchestrated by the prisoner she had argued with on 6 March.
52. The officer told the investigator that the women were deliberately intimidating Ms Whitchurch. This started when Ms Whitchurch argued with the prisoner on 6 March. ACCT procedures were restarted because Ms Whitchurch said that she felt victimised and like ending her life. The group of women were placed on basic IEP regime for antisocial behaviour. In response to evidence that a gang culture

was developing on Kinnon Unit, the prisoner identified as the main bully with whom Ms Whitchurch had argued on 6 March, was moved to another unit.

53. In the meantime, the prisoner who had threatened Ms Whitchurch on 14 March complained that Ms Whitchurch had previously sexually assaulted her by grabbing her breasts, and the prisoner who had complained on 11 March reiterated a complaint of being sexually harassed by Ms Whitchurch. The officer said she believed that these allegations were another way for prisoners to get to Ms Whitchurch.
54. An officer investigated under violence prevention procedures. Ms Whitchurch admitted to grabbing the woman's breasts but said they were flirting. Three other prisoners wrote statements which corroborated this and stated that the prisoner Ms Whitchurch had argued with on 6 March was encouraging other prisoners on A and B spurs to bully Ms Whitchurch and spread false rumours.
55. On 15 March, the police spoke to Ms Whitchurch about the allegations that she had made homophobic remarks. Ms Whitchurch provided information about the prisoner with whom she had argued, and how she brought drugs into the prison, involved other prisoners and took illicit substances.
56. Ms Whitchurch said she did not want to attend appointments away from the spur without a member of staff. From 15 March until she took her life, officers escorted her when she needed to leave Kinnon Unit.
57. On 17 March, Ms Whitchurch told the psychiatrist that the bullying had intensified. She felt unsafe and threatened when out of her cell. The psychiatrist said officers were impressed with how Ms Whitchurch had managed herself.
58. At an ACCT review on 22 March, Ms Whitchurch said she was anxious about the pending police investigation about her allegedly sexually assaulting another prisoner. She said she was having therapy with the psychiatrist but she found it hard to cope. She said staff were supportive.

April – May 2016

59. On 4 April, an officer saw Ms Whitchurch pass an object under another prisoner's door. On 5 April, Ms Whitchurch became irate when a different prisoner was moved from her landing. She threw her lunch over a SO when he tried to calm her down. On 16 April, she said she was happy on B spur. ACCT procedures were stopped on 20 April. A post-closure review was scheduled to coincide with the decision on whether Ms Whitchurch would move to Unit 10.
60. On 20 April, staff met Ms Whitchurch to discuss Ms Whitchurch's claims of a relationship with the Unit 10 officer which she had recently repeated. Ms Whitchurch said that during a previous sentence, she had joked with other prisoners about having sexual relations with the officer in the community. She said she was questioned at the time and made it clear this was untrue.
61. Ms Whitchurch's application to move to Unit 10 was considered by custodial and healthcare staff and the consultant forensic psychiatrist. One of the requirements of residency was that the prisoner had demonstrated a month of stable behaviour - Ms Whitchurch had not done so and had also made allegations against a Unit

- 10 officer. The meeting concluded that Ms Whitchurch was not suitable to move to Unit 10 but could continue as an outreach patient. An officer endorsed this view.
62. The psychiatrist told Ms Whitchurch about the decision on 28 April. Ms Whitchurch was extremely upset by the decision. She wanted to move away from Kinnon Unit but her options were limited. Of the options available, Unit 6 was too big and she had had problems with gangs there. Units 1 and 3 were being refurbished during April and May and the main bully from A spur was on Unit 2. Things had improved for Ms Whitchurch on B spur but she had issues with another prisoner there.
 63. On 28 April, a SO completed the outstanding post-closure ACCT review. Ms Whitchurch said she was disappointed not to have been accepted on to Unit 10 but was keen to continue her individual therapy. The SO decided to keep the post-closure phase open for another week. On 4 May, the SO confirmed Ms Whitchurch's ACCT had been closed because Ms Whitchurch appeared brighter and was in a more positive mood about remaining an outreach patient on Unit 10.
 64. On 9 May, Ms Whitchurch was involved in an incident when she was locked in a cell together with another prisoner. Another prisoner was outside banging on the door, shouting. When staff opened the door, both women were covered in water. On 11 May, the Governor dismissed disciplinary charges against Ms Whitchurch and due to lack of evidence. A SO said a violent offence had been committed and put both women on basic regime for a week.
 65. On 12 May, Ms Whitchurch tied a dressing gown cord tightly around her neck after someone stole her weekly purchases from the prison shop. An officer found her sitting on her bathroom floor crying. She let the officer cut the ligature but would not talk to her. The officer began ACCT procedures with Ms Whitchurch to be observed three times an hour pending assessment. A SO gave Ms Whitchurch a smoker's pack because her tobacco had been stolen.
 66. A nurse examined Ms Whitchurch in her cell. She said the ligature had been removed and she could see a red mark around Ms Whitchurch's neck. She knew Ms Whitchurch from her several sentences in Eastwood Park. She said she was not a prolific self-harmer and did not have a history of tying ligatures. She said Ms Whitchurch was obviously upset and would not talk to her. This was unusual because she was usually quite forthcoming. She said Ms Whitchurch was not a vulnerable prisoner and always seemed to mix well and be "in the thick of it".
 67. On 13 May, Ms Whitchurch told an officer at her ACCT assessment that she was struggling on basic regime and was upset that she had not been accepted on to Unit 10. She asked for ACCT monitoring to end because she had self-harmed in anger and not to take her life. The officer said Ms Whitchurch was quite upbeat, in a relatively good place. She was happy to talk and quite chatty. The officer reduced Ms Whitchurch's observations to one an hour, but decided to continue ACCT monitoring until she finished her period on basic regime and felt more positive.
 68. On 17 May, Ms Whitchurch told staff at a review that she was feeling more positive. She said she had issues with another prisoner on B spur but this

situation had improved. She said her relationship with her sisters and her work with Nexus had given her the skills and motivation to deal with any issues and she would not harm herself again.

69. She said her sister knew about the ligature she had tied and had begged her not to do it again. They discussed the prisoner who was causing her problems. Ms Whitchurch said she was stealing things and making advances to her. Ms Whitchurch said most of the prisoners on B spur were intimidated by her. They had been in a relationship but this had now finished. An officer spoke to Ms Whitchurch after the review about her application for a women-only rehabilitation centre after release. She said Ms Whitchurch was looking forward to this. A SO stopped ACCT monitoring.

18 May 2016

70. Ms Whitchurch did not turn up for her regular appointment with the psychiatrist in the morning. The psychiatrist visited her on Kinnon Unit and Ms Whitchurch told her about the ligature she had tied the week before. She offered Ms Whitchurch an extra appointment the next morning and Ms Whitchurch accepted willingly. She said she did not think Ms Whitchurch was in imminent danger of harming herself. She had reasons not to and was thinking about the future.
71. Just before noon, a SO spoke to Ms Whitchurch; she had been crying and said she was fed up. Other prisoners borrowed things and did not return them. She said she had argued with other prisoners on the spur and had particular issues with one prisoner. The SO discussed moving Ms Whitchurch to another unit. Ms Whitchurch asked her not to send her to Unit 2 and said she had too much stuff to move. The SO said that was not a reason to stay where she was unhappy. The SO said Ms Whitchurch appeared to have cheered up a bit and she told her she would come back after lunch to discuss moving her from B spur.
72. At 12.03pm, Ms Whitchurch was walking back to her room when she appeared to hear something said by the prisoner in the cell next to hers. Ms Whitchurch ran into the prisoner's cell and a fight started. Several prisoners and staff ran to the scene. Ms Whitchurch and the other prisoner were locked in their cells. All the other prisoners remained out; both Ms Whitchurch and the other prisoner stood at their observation panels shouting while the others all shouted their opinion of the fight. The SO said her first priority was to calm everyone down. She told Ms Whitchurch she would come back and see her after lunch.
73. At 12.05pm, two prisoners opened Ms Whitchurch's observation panel and talked to her. This went on for some minutes.
74. At 12.14pm, a prisoner kicked Ms Whitchurch's door. She made a gesture for someone to come to the cell and an officer talked to Ms Whitchurch through her observation panel. The prisoner said she saw Ms Whitchurch putting some red wool around her neck. She called the officer over to the cell again and told him. CCTV shows the officer left the unit briefly, returned and began to lock the other prisoners away. The officer was on detached duty and has not been interviewed. Before they were locked away, several prisoners spoke to Ms Whitchurch. All of the prisoners were locked away by 12.19pm.

75. A SO said the officer told her that Ms Whitchurch was in her bathroom, would not respond to him and that the other prisoners said Ms Whitchurch had a blade. They went to Ms Whitchurch's cell. Ms Whitchurch was sitting in her bathroom with wool around her neck, her head in her hands, crying. She let the officer cut the wool away from her neck. Ms Whitchurch said she was fed up with being on the spur. The SO talked about moving her and Ms Whitchurch asked why she had to move. The SO said she had now fallen out with three prisoners on the spur and she could not move all of them. Ms Whitchurch mentioned how much property she had. The SO said she would not be moved immediately as they would have to find space somewhere else and Kinnon Unit was full. She told Ms Whitchurch she would come back after lunch to discuss her options and asked her if she would be alright until then. Ms Whitchurch said she would.
76. The SO said she told the other staff on duty that she was re-opening Ms Whitchurch's ACCT and she should be observed twice an hour. The SO said she knew Ms Whitchurch was impulsive and quickly lost her temper but also quickly calmed down. She had never known Ms Whitchurch to self-harm repeatedly. She also knew that Ms Whitchurch would be seen by the nurse over lunchtime. She therefore considered that two observations an hour were appropriate.
77. A prisoner said once they were locked in their cells, the other women started shouting, "tie it proper", "tie it properly the double way" and "do it proper so we know you are dead". She said the prisoner Ms Whitchurch had been having most problems with shouted the loudest.
78. A nurse and a healthcare assistant (HCA) examined Ms Whitchurch. She was sitting in her bathroom with her back to the wall, crying. She had a mark under her eye and explained she had a fight with another prisoner but would not say why. Ms Whitchurch declined medical help. The HCA said there was lots of shouting and banging on the spur and he heard other prisoners taunting Ms Whitchurch. Only one prisoner was not shouting.
79. The HCA said Ms Whitchurch had photographs of her family on her wall and he talked to her about them. She perked up and told him all about her sisters. He said he knew Ms Whitchurch from several earlier sentences and she was not known to self-harm. He said there was no indication that she intended to self-harm when he spoke to her. Ms Whitchurch was usually open if something was troubling her and was easy to talk to. He did not see a letter or writing in the bathroom. A nurse said by the time he left the cell, Ms Whitchurch had calmed down. He said he saw nothing in her behaviour that suggested she was at risk of suicide or self-harm. There was a lot of tension on the spur and the other prisoners, with one exception, were making a lot of noise. He felt that Ms Whitchurch was isolated.
80. CCTV confirms the nurse and the HCA arrived at Ms Whitchurch's room at 12.40pm and left at 12.44pm.
81. The nurse told officers he thought Ms Whitchurch's ACCT monitoring should be restarted and she should move to another spur because of the tension.

82. An officer was the lunchtime patrol officer for Kinnon Unit. In statements she gave to Avon and Somerset police she said the SO told her to check Ms Whitchurch twice every hour. At the first check, Ms Whitchurch was in her bathroom and her music was very loud. She called out to her and Ms Whitchurch shouted back that she was alright. As she left the door, she heard another prisoner shout, "fucking attention seeker". CCTV confirmed the check took place at 12.58pm.
83. At 1.28pm, the officer checked Ms Whitchurch again and saw her lying face down on the floor of her room. She radioed a code blue emergency and went into the room. She used her cut-down tool to cut a tight ligature from around Ms Whitchurch's neck. Another officer joined her and noticed another smaller ligature that she also removed. Ms Whitchurch was blue and lifeless. She began chest compressions (cardiopulmonary resuscitation). A SO closed the observation panels on the other cells and then gave Ms Whitchurch rescue breaths using a mouthpiece until nurses took over.
84. CCTV showed two nurses arrived at 1.30pm. Another two arrived at 1.31pm, carrying green and red emergency bags. Paramedics arrived at 1.39pm.
85. One nurse said she was receiving a handover from another nurse on Kinnon Unit when she heard a code blue on her radio. She went straight to Ms Whitchurch's room while her colleague collected the emergency bag. She attached a defibrillator but it showed no output and did not advise an electric shock. The nurses continued cardiopulmonary resuscitation until the paramedics arrived and took over. They managed to find a faint pulse and then the helicopter emergency service team arrived. Ms Whitchurch was taken to hospital by emergency ambulance. No restraints were applied during the journey or at the hospital.
86. The SO said that the other women on the unit were shouting unpleasant things during the attempted resuscitation and one prisoner threatened to tie a ligature around her own neck.
87. A note from Ms Whitchurch to her sisters was found in her cell. Ms Whitchurch said she was sorry but she could not go on and her actions were for the best. She did not explain further.

Contact with Ms Whitchurch's family

88. At 2.23pm on 18 May, the governor in charge of Safer Custody telephoned Ms Whitchurch's sister to tell her she had been taken to hospital. Ms Whitchurch's sisters and other family members gathered at the hospital and were present when she died on 20 May.

Support for prisoners and staff

89. After Ms Whitchurch was taken to hospital, 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.
90. The other prisoners on Ms Whitchurch's unit were told in person of her death on 20 May. The prison also posted notices about her death and offered support.

Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Ms Whitchurch's death.

Post-mortem report

91. A post mortem examination concluded that Ms Whitchurch died from hypoxic ischaemic brain injury due to ligature compression of the neck. At the time of writing, we have not received a toxicology report.

Findings

Overall care at Eastwood Park

92. Overall, Ms Whitchurch received a good level of care at Eastwood Park. There is evidence of a caring approach from staff of all disciplines and good efforts were made to work out what was best for her. Ms Whitchurch's personality disorder often made relations with prisoners and staff difficult. Sadly, she appears to have got to a point where she could no longer cope. She left a suicide note for her sisters to the effect that was sorry but she could not carry on.

Assessment of Ms Whitchurch's risk on 18 May

93. Prison Service instruction (PSI) 64/2011, on the management of prisoners at risk of harm to self, to others and from others, lists a number of risk factors and potential triggers for suicide and self-harm. Ms Whitchurch had several factors that increased her risk including deliberate self-harm, childhood trauma, substance misuse issues and personality disorder. It is a mandatory requirement that staff begin ACCT monitoring after an incident of self-harm. They must set a level of observations appropriate to the person's risk. In periods of immediate suicidal crisis, they should consider a period of constant supervision. PSI 64/2011 says constant supervision should be considered if the following reasons apply:

- 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 to take own life e.g. both in prison and recently prior to imprisonment.

94. On 18 May, Ms Whitchurch was tearful and fed up before lunch. She spoke to a psychiatrist who was not worried she was at imminent risk of harming herself. Ms Whitchurch seemed keen to attend an appointment the next morning and said she had good support from her sisters. Ms Whitchurch spoke to a SO, who offered to move her to a different unit. She too was satisfied that Ms Whitchurch was not at risk of harming herself. Ms Whitchurch appeared more positive after they discussed moving her to another cell. We are satisfied that it was reasonable not to begin suicide and self-harm monitoring at this point.

95. Ms Whitchurch was found with a ligature at 12.19pm after a fight. The SO said the ligature was tight enough for Ms Whitchurch's face to have started to change colour. The SO and an officer spent about ten minutes talking to Ms Whitchurch. Although in the context of a busy prison, this is a significant amount of time, it is actually a short period within which to be certain of a person's level of risk. The SO Savage appropriately restarted suicide and self-harm monitoring as required by PSI 64/2011. She instructed staff to check Ms Whitchurch twice an hour pending assessment.

96. The SO said she did not think a check once an hour was enough because Ms Whitchurch had just tried to harm herself. In making her decision, she

considered the fact that, in her experience, Ms Whitchurch was quick to lose her temper and self-harm impulsively but was equally quick to calm down and did not have a history of harming herself repeatedly. Ms Whitchurch had let an officer cut the material from around her neck and had appeared to cheer up. The officer was aware that a nurse was about to examine Ms Whitchurch. She promised to talk to Ms Whitchurch after lunch and discuss moving her. Ms Whitchurch said she would be alright until then.

97. We understand the SO's reasoning. She knew Ms Whitchurch and she did not believe Ms Whitchurch was in imminent danger of taking her own life. The ACCT process relies on staff using their experience and skills, as well as local and national assessment tools to determine risk. However, 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.
98. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm. Ms Whitchurch had just put a ligature around her neck which was tight enough for her face to have begun to change colour. Only the week before, she had tied another tight ligature. She was on the receiving end of some very unpleasant verbal abuse from the other prisoners on the spur. It was lunchtime patrol state, which meant that a single officer would be present only when making required checks. This meant that Ms Whitchurch would be left alone for up to half an hour. We consider that staff should err on the side of caution when determining the risk posed by prisoners who have recently self-harmed, especially when they have engaged in high-risk behaviour such as tying a ligature.
99. With the benefit of hindsight, we consider that a period of constant supervision or at least a much higher number of checks over the lunchtime period was appropriate to ensure Ms Whitchurch's safety. We make the following recommendation:

The Governor should ensure that staff fully consider all risk factors when assessing the risk of 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

100. PSI 64/2011 requires ACCT case reviews to be multidisciplinary where possible, involving staff from relevant departments and services. It is a mandatory requirement that a member of healthcare staff should attend first case reviews. ACCT monitoring was begun on Ms Whitchurch four times between September 2015 and May 2016. From the records we have seen (we have not seen the case reviews for the ACCT opened in October 2015) none of the first case reviews were attended by a member of healthcare staff. There is no record in Ms Whitchurch's medical notes of any engagement between mental health staff and the ACCT process. Only two reviews included staff other than officers and none included healthcare staff. Several reviews took place with Ms Whitchurch and only one member of staff. Even when multidisciplinary attendance is not possible, it is implicit that ACCT case reviews, which should be based on teamwork, involve more than one member of staff and this is poor practice.

101. The national instructions say that an ACCT must not be closed until all the caremap actions have been completed and the review team is satisfied that the prisoner's risk has reduced. On 20 April, staff closed an ACCT before Ms Whitchurch had heard whether she was to be allowed to move to Unit 10. In addition, this was the same day she met with staff to talk about her allegations a previous relationship with a Unit 10 officer. Her caremap noted her anxiety about this decision was a factor which increased her risk and a post-closure review was set to coincide with the day of the decision. Although we recognise that in practical terms it made little difference, strictly speaking the ACCT should have remained open until the decision was known.
102. PSI 64/2011 also includes a mandatory instruction that the ACCT plan must remain on the wing until completion of the post-closure interview. The ACCT closed on 17 May was not on the wing when the SO re-opened it on 18 May and she was unable to update it contemporaneously. We are satisfied that she informed all the staff present at the time that ACCT monitoring had restarted, nevertheless we make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:

- **Staff should hold multi-disciplinary case reviews attended by all relevant people involved in a prisoner's care. A member of healthcare staff should attend all first case reviews.**
- **Care managers should set ACCT caremap actions and review progress against caremaps at each review and not close ACCT plans until all caremap actions have been completed.**
- **ACCT plans should remain on the wing until completion of the post-closure interview.**

Bullying

103. Ms Whitchurch first mentioned problems with another prisoner on A spur on 16 February. She was immediately moved to an area of the unit where she said she felt safe and there were no other recorded incident of problems with that prisoner.
104. The situation appears to have changed for the worse when Ms Whitchurch argued with another prisoner on A spur on 6 March. Ms Whitchurch was moved immediately to B spur but there is evidence the other prisoner orchestrated a bullying campaign against Ms Whitchurch by spreading rumours about her and encouraging other prisoners to intimidate Ms Whitchurch. Matters escalated on 14 March, when a group of prisoners wore strips of Ms Whitchurch's torn trousers and banged on the window between spurs when she collected her food. An officer completed a thorough investigation and the group of prisoners were reviewed under the IEP scheme and reduced to basic regime. The officer's investigation and other security intelligence resulted in the main bully and another prisoner being moved to different residential units.
105. Ms Whitchurch said she felt unsafe leaving B spur and until her death, officers escorted her when she left the unit. Two prisoners made allegations of sexual assault and harassment against her. An investigation by an officer found

evidence that these were malicious allegations and, although Ms Whitchurch was interviewed by the police, no action resulted.

106. We are satisfied that the events on A spur on 6 and 14 March were investigated promptly and sanctions to the perpetrators were applied appropriately. As the victim, Ms Whitchurch was appropriately supported by staff, including ACCT monitoring, during this period. On 22 March, she said she was still experiencing issues from her argument of 6 March but staff were supporting her. By 16 April, she said she was happy on B spur.
107. Ms Whitchurch's experiences of bullying on B spur are less clear cut. On 12 May, Ms Whitchurch tied her dressing gown belt around her neck after her order from the prison shop was stolen. She said she was struggling on basic IEP regime and was upset that she was not moving to Unit 10. She did not mention bullying or issues with other prisoners.
108. On 17 May, Ms Whitchurch said she was still struggling "a little" with another person on the wing but the situation had improved. There is evidence that she was originally friends and that they had a relationship. Ms Whitchurch told an officer on 17 May that this prisoner stole from her and made advances to her but she appeared positive about her ability to cope and her release plans.
109. Ms Whitchurch confided most in the psychiatrist, who described the bullying Ms Whitchurch had suffered on A spur as "viciously undermining". She supported Ms Whitchurch moving from Kinnon Unit but did not think the situation represented an immediate danger to Ms Whitchurch's welfare.
110. On 18 May, Ms Whitchurch spoke to a SO directly about her problems with other prisoners and said she was fed up on B spur. The SO offered to move Ms Whitchurch but she was not immediately keen. The SO said she would discuss options with her after lunch so Ms Whitchurch knew that there was potential for her to move away from the prisoner.
111. We are satisfied that the relationship between Ms Whitchurch and the other prisoner was not straightforward and that Ms Whitchurch did not appear obviously vulnerable or a victim of bullying on B spur.

The decision not to move Ms Whitchurch to Unit 10

112. The assessment process for residency on Unit 10 is appropriately lengthy and comprehensive. The prisoner's entire record is examined and staff on their current unit and on Unit 10 are also consulted. While ideally, the needs of the patient should not be compromised by staff sensitivities, we recognise that managers have to consider the impact of decisions on the institution as a whole. We are satisfied that considerable thought and discussion amongst a range of professionals went into the decision not to move Ms Whitchurch to Unit 10. Ms Whitchurch had not demonstrated the required period of stable behaviour and she appears to have reiterated allegations about an officer on Unit 10. We consider the decision not to accept her on Unit 10 was reasonable in the circumstances.

The wider picture of bullying and drug culture at Eastwood Park

113. During this investigation and our investigation into a previous death on Kinnon Unit, staff expressed concerns about Kinnon Unit and their ability to police effectively the medication hatches to prevent the diversion of medication and the resultant bullying. Kinnon Unit has always had a difficult prisoner group because it is the detoxification unit, where many prisoners begin their sentences. The perception of staff was that there were too few staff and prisoners were kept in their cells more often than on other units.
114. The high number of prisoners subject to suicide and self-harm monitoring on Kinnon Unit meant officers were further stretched and found it hard to monitor prisoners properly and ensure their safety. The unit had a high number of new officers and the deaths of Ms Whitchurch and the prisoner who died before her had had a big impact. Staff sickness levels had increased and some officers were unwilling to work there.
115. It is clear that the safety and management of Kinnon Unit gives considerable cause for concern. Moreover, the current configuration of services at the prison appears to constrain the options available to manage some of the challenging behaviours we describe. It is not clear, for example, where else in the prison prisoners who are detoxifying, but who also may be involved in bullying, can be located. We understand that the Governor has commissioned an internal review of the Unit but given the wider implications, potentially beyond the prison itself, we recommend that the Deputy Director of the Women's Estate oversees this exercise.

The Deputy Director of Custody for the Women's Estate should oversee a review of Kinnon Unit and ensure that the range of risks and needs of all women at Eastwood Park can be appropriately addressed.

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