

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Stacey Ellicott a prisoner at HMP Eastwood Park on 2 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 Ellicott was found hanged in her cell at HMP Eastwood Park on 26 April 2016. She was taken to hospital by ambulance but died on 2 May. Ms Ellicott was 35 years old. I offer my condolences to Ms Ellicott's family and friends.

There is evidence that Ms Ellicott was involved in the drug culture at Eastwood Park and in trying to bring drugs in to the prison during visits. As a result, I consider it was reasonable for staff put her on a period of closed visits for one month. Ms Ellicott admitted taking illicit subutex in the days before her death. On the day she hanged herself, she was angry that her closed visits had been extended for another month and other prisoners said she had withdrawal symptoms.

Although she was upset and angry, there were no obvious signs that Ms Ellicott wanted to take her own life. I consider it would have been difficult for staff to have predicted or prevented her death.

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

January 2017

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Summary

Events

1. Ms Stacey Ellicott had a history of substance misuse, mental health problems and self-harm by cutting. She had served several sentences at Eastwood Park over a number of years and was well known to staff and prisoners. She was not regarded as a risk of suicide and had no history of attempted suicide.
2. Ms Ellicott arrived at HMP Eastwood Park for the last time on 25 January 2016. Her mood and demeanour had not changed from previous sentences. There is evidence that Ms Ellicott was involved in the prison's drug culture. She was found trying to divert her medication twice and seen swallowing a package, suspected to be drugs, twice. Another prisoner told staff more than once that Ms Ellicott was involved in trying to get drugs passed in to the prison during visits.
3. A drug dog indicated the possible presence of drugs on her fiancé twice during visits in March. Ms Ellicott was put on closed visits for one month on 19 March. Ms Ellicott was prevented from attending therapeutic courses at Eastwood Park because of intelligence that she was involved in the drug culture.
4. On 21 April, Ms Ellicott admitted she had been taking illicit subutex (an opioid used for detoxification). On 24 April, staff began monitoring Ms Ellicott's risk of suicide and self-harm after she cut her arms in frustration. Prison staff monitored Ms Ellicott's telephone calls and heard her asking her fiancé to send her money. Another prisoner told officers that Ms Ellicott's fiancé was putting her boyfriend under pressure to pass drugs to her during visits. On 26 April, staff told Ms Ellicott that she would be on closed visits for another month. The decision made her angry and upset.
5. At 8.00pm, an officer increased Ms Ellicott's observations from one to two an hour. At the next check, Ms Ellicott was found hanging behind her cell door. Nurses performed cardiopulmonary resuscitation until paramedics arrived. Ms Ellicott was taken to hospital by ambulance but died on 2 May.

Findings

6. Ms Ellicott was involved in the drug culture at Eastwood Park and decisions made on 19 March and 25 April to put her on a period of closed visits for one month were reasonable.
7. Although Ms Ellicott had some factors which increased her risk of suicide and self-harm there was no obvious sign that Ms Ellicott wanted to take her own life, and we recognise that it would have been difficult for staff to have predicted or prevented her actions. We do not consider that the weight of her risk factors was sufficient to outweigh staff and other prisoner's perceptions of her mood and demeanour.

Recommendations

- There are no recommendations.

The Investigation Process

8. 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.
9. The investigator visited Eastwood Park on 18 May 2016. She obtained copies of relevant extracts from Ms Ellicott's prison and medical records and watched a CCTV recording from 2 May 2016.
10. NHS England commissioned a clinical reviewer to review Ms Ellicott's clinical care at the prison.
11. The investigator interviewed nine members of staff and three prisoners at Eastwood Park during May and July 2016. The clinical reviewer joined her for seven of the interviews.
12. 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.
13. One of the Ombudsman's family liaison officers contacted Ms Ellicott's father to explain the investigation. Ms Ellicott's father wrote us a detailed list of questions about the events of 26 April. He also asked about her telephone calls, letters and the prison's procedure for investigating bullying. These, and his comments on the draft version of this report, have been dealt with in this report and in separate correspondence.

Background Information

HMP Eastwood Park

14. 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

15. The most recent inspection of HMP Eastwood Park was in November 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

16. 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

17. Ms Ellicott was the first prisoner to take her life at Eastwood Park since 2007. Two other prisoners took their life shortly after Ms Ellicott in May and July 2016. There were some issues in common with the other death in May 2016, but at the time of writing, we have not completed our initial report into that death.

Assessment, Care in Custody and Teamwork

18. 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.
19. 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.

20. 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.

Key Events

21. On 29 January 2016, Ms Stacey Ellicott was sentenced to twelve months for theft and breach of an antisocial behaviour order. Her sentence was reduced on appeal to eight months and 29 days and her release date was 13 June 2016. Ms Ellicott had served a number of prison sentences for offences related to substance misuse. She was released from the most recent of these from Eastwood Park on 16 December 2015.
22. At an initial health assessment, Ms Ellicott told a healthcare assistant that she had harmed herself in prison by cutting about six months previously. She said she had accidentally overdosed on drugs three times in the community since 16 December. Her urine tested positive for heroin and benzodiazepines. The healthcare assistant referred Ms Ellicott to the GP and the substance misuse team.
23. A prison GP examined Ms Ellicott immediately afterwards. The GP noted she was prescribed fluoxetine (an antidepressant) and pregabalin (a painkiller with addictive properties). They discussed reducing Ms Ellicott's pregabalin, as it did not seem appropriate given her substance misuse issues. Ms Ellicott began a methadone maintenance programme pending detoxification and started benzodiazepine detoxification immediately.
24. On 3 February, Ms Ellicott's community GP confirmed her prescriptions for fluoxetine and pregabalin. On 4 February, Ms Ellicott and a prison GP agreed to begin reducing her pregabalin by 100mg a week. Ms Ellicott said she wanted to remain on a maintenance dose of methadone for another week before beginning detoxification. She re-started Ms Ellicott's prescription for fluoxetine.
25. On 6 February, other prisoners told officers that a prisoner had brought crack cocaine and heroin in with her and that Ms Ellicott was one of several prisoners who had smoked it on the wing that afternoon.
26. On 10 February, a healthcare assistant noted that Ms Ellicott appeared drowsy and barely coherent. He told officers he suspected she had taken something on top of her prescribed medication. The GP stopped Ms Ellicott's fluoxetine as a precaution because of its sedative properties. The same day, Ms Ellicott reported that two prisoners had bullied her for her pregabalin. The information report in Ms Ellicott's security file noted that the information had been emailed to the safer custody department so they could offer Ms Ellicott support.
27. On 13 February, an officer found a concealed pregabalin tablet when she checked Ms Ellicott's mouth after morning medication. She placed Ms Ellicott on a disciplinary charge for concealing her medication. The same day, another officer found Ms Ellicott trying to conceal her pregabalin at evening medication. She also placed Ms Ellicott on a disciplinary charge.
28. On 15 February, the Governor found Ms Ellicott guilty of the first charge at a disciplinary hearing. She fined Ms Ellicott half of her weekly wages, stopped her attending social time and recreation, and removed her television for three days.

29. On 18 February, the Governor found Ms Ellicott guilty at her second disciplinary hearing. She fined Ms Ellicott 80% of her weekly earnings and stopped Ms Ellicott's access to social time and the prison shop for a week.
30. On 25 February, a nurse reviewed Ms Ellicott's substance misuse clinical management plan. Ms Ellicott agreed to start reducing her methadone by 5mg a week. She said she had not received any fluoxetine for a couple of weeks. The nurse noted the decision to stop it had not been reviewed. A prison GP re-prescribed it the next day.
31. On 29 February, a substance misuse support worker assessed Ms Ellicott for group work on the Stepping Stones programme (a programme supporting prisoners with drug and alcohol problems). Ms Ellicott said she had been feeling low in mood but was waiting for her antidepressants to start working as she had only re-started them the previous day. She referred Ms Ellicott to groups on mindfulness and Safety First (a group supporting women with complex trauma).
32. On 2 March, Ms Ellicott told a nurse that she wanted to increase the rate of her methadone detoxification so she had more time to become stable before release. The nurse said she did not remember this specifically but she probably advised Ms Ellicott against this. Subsequent entries show that Ms Ellicott remained on the original plan to reduce her methadone by 5mg a week. The weekly Stepping Stones meeting put Ms Ellicott on the waiting list for the mindfulness course and decided to assess her further for Safety First.
33. On 10 March, Ms Ellicott started working as a servery orderly on A spur on Kinnon Unit.
34. On 11 March, the safer custody administrative officer received a telephone call from Ms Ellicott's cousin, saying that Ms Ellicott was being bullied to bring in drugs during a visit and would be beaten up if she did not comply. Ms Ellicott would not tell her cousin the names of those bullying her. He said he would ask the safer custody orderlies – trusted prisoners - to visit Ms Ellicott. He submitted an information report to the security department. The Head of Safer Custody said that the safer custody orderlies kept a book to remind them who to visit but did not necessarily write down every prisoner's name. Ms Ellicott's name appeared in the book, indicating that the orderlies visited her on 11 March.
35. On 12 March, a drug dog indicated the possible presence of drugs on Ms Ellicott's fiancé when he visited her. Ms Ellicott and her fiancé had a closed visit. A security information report was submitted and the analyst suggested that Ms Ellicott should have a period of closed visits and repeated that further investigation into the allegation made by her cousin that she was being bullied should take place.
36. On 13 March, a drug dog showed a slight interest in Ms Ellicott's fiancé and they had a visit at the high risk visits table under the close supervision of officers. Officers thought that Ms Ellicott, her fiancé and another prisoner were acting suspiciously during their visits. Female officers strip searched both prisoners after their visits but nothing was found. A note on Ms Ellicott's security file said that, despite the recent interest from the drug dog, the threshold for placing her

on closed visits had not been reached. Instead, Ms Ellicott would have future visits at the high risk table.

37. On 14 March, an officer identified Ms Ellicott as one of a group of prisoners wearing torn clothing belonging to another prisoner. The officer said the group of prisoners lined up and banged the window between A and B spur when the prisoner was collecting her lunch. The prisoner concerned was frightened and intimidated. Ms Ellicott and the other women in the group were placed on basic regime under the incentives and earned privileges (IEP) scheme for antisocial behaviour. Ms Ellicott also lost her job as servery orderly.
38. An information report was submitted to the security department. A security analyst noted evidence that a gang culture was developing on Kinnon Unit and recommended that staff considered splitting up some of the main players. The information was emailed to the Kinnon Unit manager.
39. On the same day, another information report was submitted reporting Ms Ellicott and another prisoner acting suspiciously. The security department emailed the Kinnon Unit manager to ask for Ms Ellicott's cell to be searched when he had staff available.
40. On 15 March, an assistant psychologist assessed Ms Ellicott for the Safety First group. Ms Ellicott said she had nightmares, flashbacks and intrusive thoughts as a result of childhood abuse. She was agitated and frustrated that she did not have a television because it was the only way she could successfully distract herself. The psychologist offered her alternative distraction materials but Ms Ellicott said she did not want them.
41. The assistant psychologist said Ms Ellicott told her she was on basic regime for bullying and intimidating behaviour. She had worn a strip of another prisoner's clothing but said she had not known where the clothing came from. The psychologist decided to find out more about the incident to properly assess Ms Ellicott's suitability for Safety First.
42. On the same day, another prisoner was moved to another unit as a result of investigations into the gang culture on Kinnon. This prisoner named another prisoner as the main bully and drug runner on Kinnon. She said several women on the unit were intimidated into using their trusted jobs on the servery and as cleaners to pass drugs and divert medication. The prisoner said the woman she had identified also organised family and friends, including Ms Ellicott's fiancé, to meet outside to bring drugs in during visits.
43. On 16 March, a custodial manager told the assistant psychologist that Ms Ellicott was not suitable for Stepping Stones group work because she was suspected of trading and concealing medication. She explained that the groups are run by the mental health team in an area between Residential Unit 4 and Residential Unit 1 and is not patrolled by officers. As the groups are attended by vulnerable women, it is not appropriate that women being investigated for trading medication and bullying do so.
44. On 18 March, Ms Ellicott cut her left arm with a razor. An officer began ACCT procedures. Ms Ellicott said she felt low and that no one was listening to her. He

assessed Ms Ellicott the next morning. Ms Ellicott said that without her television she had nothing to distract her during periods when she was locked in her cell. She lived in the cell at the end of the landing, which meant she had fewer neighbours to talk to. She had lost her job and was worried about getting it back. Ms Ellicott said she had cut her arms out of frustration and had not intended to kill herself.

45. A senior officer (SO) reviewed Ms Ellicott alone later the same afternoon. The officer briefed to him beforehand but did not attend the review. Ms Ellicott said she had cut her arms because she could not cope without a television. The SO added an action to the caremap, which was to address the television issue when Ms Ellicott's IEP scheme level was reviewed on 21 March.
46. On 19 March, the same prisoner who had given information before, told two officers that the prisoner she had named as the main bully on Kinnon Unit, had pressured her to make her boyfriend meet Ms Ellicott's boyfriend in a pub and pass him subutex tablets to give Ms Ellicott during a visit. The 'pass' had not taken place but Ms Ellicott's boyfriend was going to send subutex to her in a confidential legal letter. The prisoner said the alleged main bully had people running drugs for her all over the prison and people were scared of her. The prison sent a warning letter to Ms Ellicott's boyfriend and put Ms Ellicott on closed visits for one month.
47. On 21 March, Ms Ellicott was returned to standard level of the IEP scheme at a review. The same day, the assistant psychologist discussed her with the clinical psychologist. They agreed she should see Ms Ellicott again and should complete the Millon Clinical Multiaxial Inventory (MCMI – a questionnaire designed to assess personality disorders).
48. On 22 March, a SO and an officer reviewed Ms Ellicott as part of ACCT procedures. She said Ms Ellicott still did not have a television in her cell despite being returned to standard regime the day before. The SO said he would try to find one for her. He decided that Ms Ellicott's risk remained low and she should remain on hourly observations. He made a note to invite a member of the substance misuse team to the next review.
49. On 1 April, a SO, an officer and a worker from the substance misuse team reviewed Ms Ellicott. Ms Ellicott was in a good mood and said she was in a good place. She was working as a wing painter. The review team decided to stop ACCT monitoring.
50. On 7 April, the SO completed a post-closure ACCT review. Ms Ellicott said she had not felt fully supported during the time she felt like harming herself but her issues were now resolved.
51. On 10 April, an officer monitoring the prisoner telephone system, heard Ms Ellicott ask her fiancé to send £40 to Prisoner A. He asked why and she said 'I can't say on here, can I'. A security analyst suggested officers search both women. The same day the same prisoner who had given information to staff before told an officer that Ms Ellicott's fiancé was trying to get her boyfriend to pass subutex to her to give to Ms Ellicott. She said that when the drug dog

- identified him previously, he had subutex with him but now Ms Ellicott was on closed visits, he was unable get it to her.
52. The same day, another prisoner told officers she was frightened that Ms Ellicott and Prisoner A were going to beat her up for telling officers that Prisoner A had brought Quetiapine into the prison from court at the end of March.
 53. At 9.45am on 13 April, two officers searched Ms Ellicott after one officer saw her take what she believed to be a 'wrap' out of her bra and put it in her mouth. She asked her to spit the package out but she swallowed it. She asked Ms Ellicott if she had anything in her cell and Ms Ellicott said she had a pregabalin tablet concealed in her safe. Both officers searched Ms Ellicott's cell and found the tablet. They submitted an information report to the security department but it was not reviewed by an analyst due to staff absence.
 54. At 11.50am on 13 April, an officer saw Ms Ellicott acting suspiciously in Pathways healthcare centre and noticed a package in her hand. Ms Ellicott then put the package in her mouth and swallowed it. Ms Ellicott was strip searched in reception by two officers. They found a letter from the prisoner named as the main bully asking Ms Ellicott to "sort some stuff" as she had nothing in her unit. Ms Ellicott was put on basic regime for seven days and her television was removed. A security analyst suggested both women should have a mandatory drug test.
 55. On 14 April, Ms Ellicott attended disciplinary hearings for both incidents the previous day. She was fined a total loss of 80% of her earnings and social time for three weeks.
 56. On 20 April, Ms Ellicott returned to the standard IEP level. The weekly Stepping Stones meeting noted that Ms Ellicott was still on the waiting list for Safety First and mindfulness course.
 57. On 21 April, Ms Ellicott attended a session with a worker from the substance misuse team. (She has left Eastwood Park and was not interviewed). Ms Ellicott disclosed she had been using illicit subutex since finishing her methadone detoxification. She agreed to consider starting a course of lofexidine (used to reduce symptoms of opiate withdrawal) to help manage her withdrawal from subutex. Ms Ellicott said that the person supplying her was prescribed subutex but would not say who it was.
 58. The same day she spoke to her fiancé for nine minutes by telephone. We have not listened to the conversation as the prison had not kept a copy. An entry in her security record said that her fiancé was upset that she was in prison. Ms Ellicott reassured him that it was not for much longer. She asked him to send her £40 but said she could not tell him why she needed it on the telephone. This was her last telephone call.
 59. On 22 April, a nurse completed a screening assessment to see if Ms Ellicott was eligible for community mental health services on her release from prison. She said Ms Ellicott presented well but described her mood as variable. She said she heard the voices of her male abusers. She said these voices appeared to be caused by trauma rather than psychosis. She concluded that Ms Ellicott was not

suffering from a significant mental illness and would benefit from psychological support. She planned to discuss the mindfulness referral with the mental health team and discharged Ms Ellicott from her caseload.

60. On 24 April, Ms Ellicott made cuts to her right arm using a razor. An officer began ACCT procedures. Another officer assessed Ms Ellicott at 5.00pm. Ms Ellicott said she was stressed and angry with certain people on the wing. She said she had too much to handle and had cut her arm due to frustration. She said it was a coping mechanism and a form of release rather than an attempt to end her life. She did not feel seriously suicidal but said she had moments of not wanting to live. Ms Ellicott said she was not sleeping well because she was withdrawing. The officer decided that Ms Ellicott should remain on hourly observations.
61. A SO and an officer reviewed Ms Ellicott after her assessment. The SO wrote that Ms Ellicott was feeling low due to issues with some of the other prisoners on the wing. Staff had not completed Ms Ellicott's caremap.
62. At 6.30pm Ms Ellicott complained of chest pain. She told an officer that she felt anxious because B spur was very unsettled. A nurse examined her, gave her an inhaler and reassured her the chest pain was not cardiac.
63. At 4.43pm on 25 April, a healthcare assistant checked Ms Ellicott's wound dressing. Ms Ellicott told her that she was in a low mood and struggling with detoxification. She asked to see her substance misuse worker as soon as possible and the healthcare assistant said she would check if she was in (she was not).
64. An officer wrote a monthly wing comment on Ms Ellicott's prisoner record. He said, "Not a good month for Stacey, has had a lot of intel regarding drugs and has been found a few times suggesting intel is correct. Stacey then got very funny when told she would not be keeping her painting job on the wing because of this. I now believe Stacey is trying to get other wing workers sacked so she can persuade people from her 'group' to be employed giving her another route to trade".
65. The same day, a Governor reviewed Ms Ellicott and decided she should remain on closed visits for another month. Ms Ellicott's ACCT record shows she was still feeling down and complained about noise on the wing.
66. Prisoner A said she met Ms Ellicott in prison and they had been friends for about eight or nine years. She said Ms Ellicott was easily led and had been persuaded to take illicit subutex after finishing her methadone detoxification. She did not think Ms Ellicott had been bullied. She said Ms Ellicott had received upsetting news about both of her children in the weeks before she died.
67. Prisoner A said Ms Ellicott was also worried that her fiancé was about to finish their relationship because he found it hard to cope with her being in prison and subject to closed visits. He did not want to spend the time and money to visit her in those circumstances, so closed visits effectively meant no visits.
68. Another prisoner said she had known Ms Ellicott for a number of years in prison. She did not know Ms Ellicott as a self-harmer although she knew Ms Ellicott had

cut her arms during her most recent sentence. She said Ms Ellicott had argued with her boyfriend about money for subutex that Ms Ellicott had got from another prisoner. She was also upset about being put on closed visits. Her boyfriend had been due to visit that weekend and now was not going to come.

69. Another prisoner had also known Ms Ellicott for a number of years in prison. She said Ms Ellicott found it hard to cope with spending a lot of time locked in her cell. She said Ms Ellicott was not vulnerable in prison and not a target of bullying.

26 April 2016

70. At 10.07am, Ms Ellicott spoke to a nurse in the substance misuse clinic. She agreed to begin a five day lofexidine detoxification, starting on 27 April. At 10.31am, Ms Ellicott saw a prison GP, who prescribed her lofexidine. Ms Ellicott complained of pain in her lower leg. She said that she no longer took pregabalin and was struggling with the effects of withdrawal from methadone and subutex. She agreed to start Ms Ellicott on a titrating dose of Amitryptilline (an antidepressant used to treat depression, anxiety and neuropathic pain) but advised it would take several weeks to achieve a therapeutic effect.
71. In the afternoon, Ms Ellicott made a general application for emergency credit for her prison telephone account. She said her partner had been robbed at knifepoint, and she wanted to talk to him. According to her ACCT record, she asked for emergency telephone credit at about 6.00pm but was told it was not possible. (General applications are put in a box on the wing. Emergency credit would have to be put on the system by the business hub, who were not on duty at 6.00pm.)
72. Officer A was on duty on Kinnon Unit all day until 7.30pm and told Ms Ellicott about the Governor's decision to put her on closed visits for another month. He said Ms Ellicott was very angry about the decision, especially because he could not tell her why. He told her she could make an application to find out why. Although Ms Ellicott was angry, she was not tearful, and she continued to talk to officers and prisoners on the unit as normal.
73. Officer B said she came on duty at about 5.30pm. Ms Ellicott told her she did not understand why she had been put on closed visits for another month. She told Ms Ellicott to complete a general application form and said she would make sure that someone telephoned the security department in the morning to ask. She also advised her to complete a complaint form. Ms Ellicott completed an application form and wrote she felt "victimised and down". As she was still very angry, she told her to have a cigarette in Prisoner A's room to help her calm down.
74. CCTV was retained by Eastwood Park after Ms Ellicott died. The time on the CCTV was an hour behind the correct time. We have used the correct time in the following account.
75. Officer B locked Ms Ellicott into her cell at 6.50pm. She said Ms Ellicott asked her for a razor. She told her she wanted to talk to her first. Ms Ellicott asked her for a razor again when she was locking the other prisoners in their cells. She told

- her she would come back when she had finished locking up. She told the other staff on duty not to give Ms Ellicott a razor until she had spoken to her.
76. Prisoner A said she had a coffee and a chat with Ms Ellicott before lock in. She said she heard Ms Ellicott asking for a razor and had told the officers not to give her one. Ms Ellicott said, "I don't want to kill myself, I just want to get this anger out". She said she was worried Ms Ellicott would cut herself if she had a razor but did not think that she wanted to take her life.
 77. Another prisoner said she spoke to Ms Ellicott through her cell door and told her to go to bed and watch television but Ms Ellicott told her she could not concentrate. She did not think that Ms Ellicott wanted to take her life. She told Officer B not to give Ms Ellicott a razor because she was still really angry. CCTV shows several prisoners, including Prisoner A and this prisoner, speaking to Ms Ellicott through her door before they were locked up. Officer B locked the remaining prisoners in their cells at 7.18pm. Afterwards, Ms Ellicott looked out of her observation panel several times.
 78. At 7.32pm, Officer A stopped to talk to Ms Ellicott at her observation panel. He could not remember what they spoke about but had a vague recollection of Prisoner A telling him not to give Ms Ellicott a razor. Ms Ellicott closed her observation panel at 7.34pm.
 79. At 7.37pm, Ms Ellicott's cell bell light came on and she opened her observation panel again. At 7.40pm, Officer B answered the bell. Ms Ellicott again spoke about the decision to put her on closed visits and asked for a razor.
 80. Officer B noted on Ms Ellicott's ACCT record that Ms Ellicott was very emotional and other prisoners had told her that she was feeling very down. She said she told the incoming night staff and decided to increase Ms Ellicott's observations to two an hour. She did not document this but made her next check at 8.05pm, as a result. She said Ms Ellicott was sitting at the back of her cell on the floor. She shouted at her and asked her why she would not give her a razor. She tried to calm Ms Ellicott down and told her she was not comfortable giving her a razor. She said she would try to find out the reason why Ms Ellicott had been put on closed visits for another month. Ms Ellicott would not calm down and told her to go away.
 81. At 8.10pm, CCTV footage showed Ms Ellicott opening her observation panel again. At 8.13pm, she put her arm out of her hatch and reached across the door towards the hinge side. The hinge side of the door is not visible on the footage. At 8.16pm, she appeared to pull a length of material from the hinge side of the door through the observation panel. It is possible to see movement behind the door for about 30 seconds afterwards.
 82. At 8.32pm, Officer B returned to Ms Ellicott's cell. She noticed Ms Ellicott to the side of the door with something round her neck and realised it was a ligature. She shouted to Ms Ellicott and ran to get Officer C from the landing upstairs. They opened the cell door and Officer C radioed a code blue medical emergency. Officer B lifted Ms Ellicott up and Officer C used his cut-down tool to cut through the ligature. They put Ms Ellicott on the floor as nurses arrived. CCTV confirms both officers opened the cell at 8.33pm.

83. A nurse said she was in the Kinnon Unit office on the landing above Ms Ellicott's cell when she heard the code blue. She went straight to Ms Ellicott's cell with another nurse who collected the emergency response bag. She began cardiopulmonary resuscitation. She said Ms Ellicott had no pulse and appeared lifeless. Her colleagues arrived very soon after. They gave Ms Ellicott oxygen and attached a defibrillator. The defibrillator did not advise an electric shock so the nurses continued cardiopulmonary resuscitation.
84. CCTV showed both nurses arriving at 8.34pm, followed by more healthcare staff with more emergency bags, at 8.35pm.
85. The control room officer called an ambulance immediately after Officer C radioed code blue. The patient contact record from South West Ambulance Service noted the emergency call was received at 8.31pm. Paramedics arrived at the cell at 8.57pm. They managed to find an output from Ms Ellicott's heart and took her to hospital by ambulance.
86. Ms Ellicott was put on life support in the intensive care unit but died on 2 May, without regaining consciousness. No restraints were used and escorting officers waited in an adjoining waiting room to allow Ms Ellicott's family to visit privately.
87. Information received from prisoners after 26 April, indicated that Ms Ellicott was extremely upset about having closed visits. She was struggling to get hold of subutex and was withdrawing. She had last used subutex on the morning of 26 April.

Contact with Ms Ellicott's family

88. At 10.30pm on 26 April, a Governor telephoned Ms Ellicott's ex-partner (Ms Ellicott had given his name as her emergency contact) to tell him she had been taken to hospital. Mr Ellicott's ex-partner said he would telephone her father. Both Ms Ellicott's parents and other family members gathered at the hospital and some were present when she died.
89. Ms Ellicott's father provided the investigator with her letters to her fiancé. Ms Ellicott referred to feeling frustrated about other prisoners (with mental health problems) disturbing her sleep and about being placed on closed visits. She said on 26 April that she was suffering from withdrawal symptoms. There is nothing in the letters to indicate that she intended to take her own life.

Support for prisoners and staff

90. After Ms Ellicott 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.
91. The other prisoners on Ms Ellicott's unit were told in person of her death on 2 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 Ellicott's death.

Post-mortem report

92. A post mortem report concluded that Ms Ellicott died from hypoxic brain injury and bilateral bronchopneumonia due to hanging. A toxicology report was not completed.

Findings

The decision to put Ms Ellicott on closed visits

93. Chapter three of PSI 15/2011, Management and security at visits, gives guidance on applying closed visits. Closed visits should be used where prisoners are proved, or reasonably suspected of, being involved in smuggling prohibited items during visits. Evidence found on the balance of probabilities, as opposed to beyond reasonable doubt, is sufficient. Before applying closed visits, the prison is required to demonstrate that they have taken into account all the individual circumstances of the case, have acted proportionately and have kept the decision under review. Amongst other things, they should consider the type of prohibited item, previous history of involvement with it, security intelligence and telephone monitoring evidence.
94. Eastwood Park's local policy on closed visits includes a risk evaluation that must be completed before a prisoner can be considered for closed visits. Prisoners are scored on answers to a variety of questions about frequency of supporting intelligence and potential risk to the prison's drug strategy. A low score of under 30 results in a prisoner being placed on the high risk table at visits, with closer observation by staff. A score between 30 and 70 equates to medium risk and results in closed visits for one month. Over 70 is a high score and results in closed visits for three months.
95. Ms Ellicott was placed on closed visits on 19 March. In the period leading up to this, the following had happened:
- On 11 March, her cousin rang the prison to say she was being bullied to bring drugs in on visits.
 - On 12 March, a drug dog indicated her fiancé at a visit.
 - On 13 March, a drug dog showed a slight interest in her fiancé and Ms Ellicott was noticed to be acting suspiciously during her visit.
 - On 15 March, another prisoner told officers that Ms Ellicott's fiancé was bringing drugs into the prison on visits.
 - On 19 March, the same prisoner told officers that Ms Ellicott's fiancé was going to send her subutex in a letter.
96. According to Eastwood Park's local security policy, Ms Ellicott reached the threshold for closed visits for one month. There was also other evidence that Ms Ellicott was involved in the drug culture in the prison. She had been caught trying to divert her medication, had been named as someone who had smoked heroin and crack cocaine on the wing and had appeared under the influence of something other than her medication.
97. The decision to apply closed visits must be for a specific period of time and be reviewed monthly. A further period of closed visits is allowed if a subsequent incident indicates renewed risk. The decision in Ms Ellicott's case was reviewed appropriately after one month. On 10 April, monitoring of the prison telephone

system showed Ms Ellicott asking her fiancé to send in money to another prisoner. The same day, another prisoner told officers that Ms Ellicott's fiancé was putting pressure on her boyfriend to bring in drugs on a visit to give to Ms Ellicott. On 13 April, Ms Ellicott was seen to swallow a package and a letter from another prisoner asking her to "sort some stuff" was found on her.

98. We are therefore satisfied that the decisions to put her on closed visits for one month on 19 March and another month on 25 April were reasonable under the terms of PSI 15/2011 and according to Eastwood Park's policy.

Assessment of risk of suicide and self-harm

99. 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 Ellicott had some factors that increased her risk including previous self-harm, childhood abuse, substance misuse issues, relationship problems and mental health issues.
100. Ms Ellicott had a history of self-harm by cutting but there is no record of her having tried to hang herself or put anything round her neck to harm herself. She was monitored under ACCT procedures several times but this was for self-harm rather than suicidal intent. Neither staff nor prisoners who knew Ms Ellicott in prison for many years regarded her as at risk of suicide.
101. Ms Ellicott was angry and frustrated on 26 April. She had admitted taking illicit subutex in the days before, and there is anecdotal evidence that she was suffering from withdrawal. While it was upsetting for Ms Ellicott, there is evidence that her being on closed visits cut off a potential supply of drugs for her. Prisoners told us that she had received two pieces of upsetting news about her children that week, but staff were not aware of this.
102. Staff monitored Ms Ellicott's risk of suicide and self-harm after making superficial cuts to her arms on 24 April. She asked Officer B several times during the evening of 26 April for a razor. She increased Ms Ellicott's level of observations from one to two an hour. She said she was not concerned that Ms Ellicott wanted to take her life but she was angry and upset. She wanted her to have more support that night. There was no obvious sign that Ms Ellicott wanted to take her own life, and we recognise that it would have been difficult for staff to have predicted or prevented her actions. We do not consider that the weight of her risk factors was sufficient to outweigh staff and other prisoner's perceptions of her mood and demeanour.

**Prisons &
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