

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Ms Mangui Fu a prisoner at HMP New Hall on 13 October 2017

**A report by the Prisons and Probation Ombudsman**

PO Box 70769  
London, SE1P 4XY

Email: [mail@ppo.gsi.gov.uk](mailto:mail@ppo.gsi.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100  
F | 020 7633 4141

## 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*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Mangui Fu was found hanged in her cell at HMP New Hall on 13 October 2017. She was 41 years old. I offer my condolences to Ms Fu's family and friends.

Ms Fu had been at New Hall for only four nights when she was found hanged. Prison staff failed to assess Ms Fu's risk of suicide and self-harm properly when she arrived on 9 October, in spite of her having a number of known risk factors. Ms Fu did not receive an initial health screen when she arrived, or throughout her time at New Hall. As a result, opportunities to start suicide and self-harm prevention measures were missed. Had they been, the outcome could have been different.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**May 2018**

## Contents

Summary .....	1
The Investigation Process.....	4
Background Information.....	5
Key Events.....	6
Findings .....	11

# Summary

## Events

1. On 9 October 2017, Ms Mangui Fu was remanded to custody at HMP New Hall charged with assault against her son and threatening and abusive language towards an adult. She had no previous convictions. Although Ms Fu was a British national, she spoke very little English.
2. Ms Fu's person escort record (PER, a document that accompanies all prisoners when they move between police stations, courts and prisons) noted that she had threatened to jump from a moving car and had depression. At her reception screening, she told prison staff, through an interpreter, that she had no thoughts of suicide or self-harm. Healthcare staff did not complete an initial health screen at reception because they did not have time before their shift ended. No health screen was ever subsequently carried out.
3. On 13 October, at around 8.40am, a prisoner alerted officers that Ms Fu was unresponsive in her cell. Staff discovered Ms Fu hanged, with a bed sheet attached to the window. Staff attempted resuscitation but at 8.54am, a prison doctor declared Ms Fu had died.

## Findings

4. Ms Fu had a number of factors that increased her risk of suicide. It was her first time in prison, she had threatened to harm herself before her arrest and was depressed. We found that Ms Fu's risk of suicide and self-harm was not properly assessed. Staff failed to consider the information that arrived with her from the police and courts and relied only on Ms Fu's presentation. We found that reception processes were disjointed and information was inaccurately recorded on documentation that accompanied Ms Fu to and from court.
5. Ms Fu never had an initial health screen which is a significant failing. She was not seen by a nurse in reception and when Ms Fu arrived on the first night centre a nurse recorded that she did not complete the health screen due to language difficulties. Ms Fu's community GP records were never requested, which would have shown she was prescribed various medications, including antidepressants.
6. There is limited information in Ms Fu's prison record and staff had little interaction with her. A member of chaplaincy met Ms Fu two days after she first arrived but, like healthcare staff, did not consider using an interpreter. Entries on Ms Fu's records by prison, healthcare and chaplaincy staff were all inadequate.
7. Staff on the first night centre carry out a welfare check at morning unlock but in some cases, this may not be until after 9.30am. We consider that welfare checks should be carried out earlier, given that these are newly arrived prisoners who are known to be vulnerable.
8. When Ms Fu was discovered, there was an eight minute delay in calling an ambulance. Resuscitation efforts should have been better coordinated and recorded, and a clear handover provided to paramedics when they arrived at New Hall.

9. The system for recording cell bells had not been maintained and cell bell records were not logged.

## Recommendations

- The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. First night procedures should recognise the additional vulnerabilities of newly arrived prisoners. In particular, this should ensure that reception, healthcare, first night staff and all others who assess risk:
  - Have a clear understanding of their responsibilities and the need to share all relevant information about risk.
  - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from Person Escort Record forms (PER) and other sources.
  - Document the information considered and the decision whether or not to open an ACCT.
  - Open an ACCT whenever a prisoner has significant risk factors, irrespective of their stated intentions.
- The Governor and Head of Healthcare should review the reception process, to ensure all documentation is available to inform assessment of risk.
- The Head of Healthcare should ensure that:
  - All new receptions have an initial healthscreen and those returning from court, or any other outside appointment, are reassessed to identify if their needs or risk has changed.
  - All abnormal urine analysis results are promptly followed up by a nurse or doctor.
  - Observations are recorded contemporaneously.
  - Every effort is made to obtain community medical records in line with PSO 3050.
- The Head of Healthcare should ensure all staff are given training and provided with clarification around CPR: when to stop and when it is appropriate to declare life extinct. A contemporaneous entry should be made on the medical record by all those directly involved.
- The Head of Healthcare should ensure that trained healthcare staff take control of resuscitation as soon as possible and provide a clear handover to attending paramedics.
- The Governor, Head of Healthcare and Head of Chaplaincy should ensure that accredited interpreting services are used by all members of staff when interviewing or assessing prisoners who do not understand English well.
- The Governor should ensure all prisoners are checked on the first night centre when unlock starts.

- The Governor and Head of Chaplaincy should ensure all chaplaincy staff record their own contacts as soon as practicable.
- The Governor should ensure that the system to record cell bells is fully operational at all times. When there is a fault, this should be reported immediately, via the appropriate reporting system, to ensure there is no delay in fixing faults.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP New Hall informing them of the investigation and asking anyone with relevant information to contact her. Nobody responded.
11. The investigator visited New Hall on 24 October 2017. She obtained copies of relevant extracts from Ms Fu's prison and medical records. She visited the wing where Ms Fu lived and spoke to prisoners and staff that had contact with her.
12. NHS England commissioned a clinical reviewer to review Ms Fu's clinical care at the prison.
13. The investigator interviewed 11 members of staff and four prisoners at New Hall on 21 and 22 November. The clinical reviewer accompanied her on 21 November. In addition, the investigator interviewed a social worker and one member of staff by telephone in November, three members of staff in December, and two members of staff in February 2018.
14. We informed HM Coroner for West Yorkshire of the investigation, who gave us the cause of death. We have sent the Coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Ms Fu's family to explain the investigation. Ms Fu's family did not raise any specific issues for the investigation to consider.
16. Ms Fu's family were informed the initial report was available, but did not wish to receive a copy or make any comment.
17. The prison received a copy of the report and identified a factual inaccuracy which has been amended.

# Background Information

## HMP New Hall

18. HMP New Hall is a local prison, holding up to 425 women and young offenders, on remand or sentenced. There is 24-hour healthcare cover. Care UK have been the healthcare provider for all physical and mental health services since 1 September 2016, although South Staffordshire and Shropshire Foundation Trust are sub-contracted to provide psychiatric and psychological services.

## HM Inspectorate of Prisons

19. The report of the most recent inspection of New Hall was in June 2015. Inspectors reported that health services were strong, particularly mental health provision. The inspectors found that support on arrival and during the early days at the prison was very good.

## Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report, for the year to February 2017, the Board noted that since Care UK replaced Spectrum/Nottingham Healthcare NHS as the primary and mental healthcare provider there had been an immediate impact resulting in a shortage of trained professionals, particularly in relation to mental health matters.

## Previous deaths at HMP New Hall

21. Before Ms Fu's death, there had been two self-inflicted deaths at New Hall in the previous two years, the most recent in April 2016, and two drug related deaths. We have previously made recommendations about the need to consider all information and adequately identify risk factors for suicide and self-harm.

## Assessment, Care in Custody and Teamwork (ACCT)

22. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

### Monday 9 October

23. On 9 October 2017, Ms Mangui Fu was remanded to HMP New Hall, charged with assault against her son and threatening and abusive behaviour towards an adult. She had not been in prison before. Ms Fu's person escort record (PER, a document that accompanies all prisoners when they move between police stations, courts and prisons) noted in the medical section that she had depression and, in the 'Details of Current and Relevant Risk' section under suicide/self-harm, it was noted Ms Fu had threatened to jump out of a moving vehicle. At 5.50pm, an officer recorded on the PER that Ms Fu had arrived at New Hall reception.
24. An officer generated a computerised prison record for Ms Fu at 6.32pm. A Supervising Officer (SO) completed Ms Fu's reception interview, including the cell sharing risk assessment (CSRA), designed to assess the risk of violence a prisoner poses. The details of the interview were recorded retrospectively in Ms Fu's prison record at 11.29am the next day. The SO noted that Ms Fu spoke little English and he used Language Line (a professional telephone interpreting service) to complete the initial assessment of her immediate needs. Ms Fu told him, through the interpreter, that she had no thoughts of suicide or self-harm. He told the investigator he recalled Ms Fu was the last person he interviewed, around 9.15pm, and the interview lasted approximately 15 minutes.
25. Two nurses were in reception completing health screens for all newly arrived prisoners. They told the investigator it was a particularly busy day and they did not have time to complete Ms Fu's assessment before their handover to the night shift at 7.30pm. Ms Fu was located in a single cell on the first night centre on C Wing (Willow Unit). An officer told the investigator that she asked Ms Fu if she wanted a sandwich, which she declined as she had been given noodles in reception.
26. A nurse started her night shift around 7.30pm, and was the only qualified nurse on duty. She was aware that there were three prisoners who needed to be assessed: two new arrivals, including Ms Fu, and a discharge from hospital. She prioritised the other two prisoners who had drug related issues. She told the investigator that she had spoken to the SO and, because Ms Fu was to be routinely checked every hour on the first night centre, decided the health screen should be completed the next day. She was unaware Ms Fu was due to appear in court the next day. She recorded in Ms Fu's medical record at 11.32pm that a reception healthscreen was unable to be completed 'due to language barrier'.
27. The nurse noted Ms Fu's urine test indicated there were no concerns about drugs or alcohol, but she did not identify that Ms Fu had tested positive for ketones, a possible indicator of diabetes or if someone has not eaten for some time. She noted the healthscreen should be completed on 10 October, using Language Line. She started a first night care plan, which included checking Ms Fu every hour. At 6.25am, she made a single entry and recorded that Ms Fu had been asleep since midnight. She told the investigator she gave a verbal handover to the day nurses at the end of her shift.

## Tuesday 10 October

28. Ms Fu was returned to court for a bail hearing and left New Hall at 8.00am. The PER completed by an officer did not include the risk details noted by the police on the previous PER, and a nurse signed the document indicating there were no physical or mental health issues. A senior healthcare support worker recorded in Ms Fu's medical record at 11.39am that she had failed to attend for her health screen, and she was to be rebooked if she returned from court. According to the PER, Ms Fu arrived in reception at 7.10pm. There is nothing noted in Ms Fu's prison record and no evidence that reception officers assessed her needs before she was returned to C Wing. Ms Fu was remanded to appear at Magistrates' Court on 12 October. Ms Fu never had a health screen and there are no other entries on her medical record before she died. The night nurse on C Wing said nobody told her Ms Fu's health screen was still outstanding.

## Wednesday 11 October

29. A prison chaplain met Ms Fu around 9.30am. The Roman Catholic chaplain recorded in Ms Fu's prison record that her colleague had met Ms Fu at 4.27pm, but there is no detail about their meeting or what they discussed.
30. At 2.35pm, a SO completed the basic custody screening (an assessment of immediate risks and needs) using Language Line, which lasted around 65 minutes. The SO incorrectly noted in section 8 that the reception health screen had been completed and did not record the concerns noted on the PER dated 9 October, about Ms Fu's threat to jump from a moving car. The SO updated Ms Fu's prison record at 4.50pm.
31. Later that evening, an officer completed Ms Fu's first night induction at 6.14pm. He recorded that Ms Fu spoke very little English and Language Line was required to converse with her. He recorded Ms Fu had no issues relating to drugs or alcohol. Ms Fu said she suffered from depression but did not want any support in prison.
32. A SO completed a discharge check at 6.32pm, and confirmed with Ms Fu that she knew she was going to court the next day. She told the investigator she did not use Language Line and spoke to Ms Fu briefly on the wing, but was satisfied that she understood she was appearing in court the next day.

## Thursday 12 October

33. On 12 October, Ms Fu was returned to court. The PER completed by an officer had no information relating to any risk issues, and a nurse recorded there was no information about Ms Fu's physical or mental health. According to the PER, Ms Fu was returned to New Hall at 6.10pm and was received by reception staff at 6.15pm. There is no information recorded in her prison record and no evidence anyone spoke to her or assessed her needs before she was returned to C Wing. An officer told the investigator that she asked Ms Fu if she wanted a sandwich, which she declined.
34. Two prisoners were located in the cells opposite Ms Fu. They told the investigator Ms Fu rang her emergency cell bell several times during the evening and night. These prisoners reported that the night patrol officer raised his voice,

swore and threatened Ms Fu with being placed on basic if she kept ringing her cell bell. Another prisoner made a similar statement to the police.

35. The night patrol officer told the investigator he had no recollection of Ms Fu pressing her cell bell on 12 October, and that he never spoke to her. He said he warned other prisoners on the wing to stop using their cell bells excessively to request medication. A prisoner told the investigator, 'I had a big argument with that night patrol officer ... I called him a prick.' The officer said he was made aware by a colleague that after Ms Fu's death other prisoners shouted to each other that they would inform the Governor that he had told Ms Fu to "fuck off". He said he believed that the other member of staff was going to submit an intelligence report, but no report was submitted.
36. The investigator requested a copy of the cell bell records for C Wing. Although the records were provided, they do not show the specific cell or timings of when a bell was pressed and answered but merely recorded 'Communication Error'.
37. An operational support grade (OSG) told the investigator he recalled a prisoner in Cell 14 (opposite Ms Fu's cell) kept pressing her cell bell asking for medication, but could not recall what night this was or the name of the prisoner. He said the night patrol officer had answered the cell bells and explained to this prisoner that she would have to wait as there were only two members of healthcare on duty, but they would come and speak to her. He said he was in the communications room during his night shift and said as far as he could recall Ms Fu never pressed her cell bell during her time at New Hall, and did not raise any concerns with staff. He was unaware the cell bell data log was not working.
38. Another OSG was also working nights on A, B and C Wing. He told the investigator that C Wing was generally a busy wing and he recalled that there were a number of prisoners ringing their cell bells asking for medication and were being quite 'rowdy' as 'nurses were running late'. He said he was certain Ms Fu had not rung her cell bell all week and that he did not hear the night patrol officer raise his voice or swear at any prisoner.
39. Prisoners told the investigator that although Ms Fu was quiet, they never had any concerns about her welfare. One prisoner said she saw Ms Fu talking to 'another Chinese prisoner' but the investigator was unable to establish who this was.

### **Friday 13 October**

40. There is no Closed Circuit Television (CCTV) on C Wing, and body-worn video cameras (BWVC) were not used. There had been a power surge on 10 October, rendering the BWVCs unusable. They were sent to the manufacturer Edesix on 13 October, and the system was fixed on 24 October.
41. Officer A arrived on the wing around 6.00am. She handed over from the night shift and did not report anything untoward. She started to complete a roll check (a count of all prisoners) on C Wing and she submitted confirmation at around 6.10am. She had no specific recollection of Ms Fu, but said all prisoners were visible in bed.
42. Two prisoners started work in the laundry around 8.30am. They were exchanging bedding on C Wing and Officer A used the tannoy around 8.35am to

alert prisoners to have their dirty bedding ready for exchange. Prisoner A knocked on Ms Fu's cell door around 8.40am, but did not get a response. She told Prisoner B, who went to Ms Fu's cell and used her issued key to open the hatch on the door (standard practice during bedding exchange). She saw Ms Fu, slightly obscured by a modesty curtain, hanging from the window by a bed sheet at the back of her cell. She shouted to prison staff that she could not get a response. Two officers said it was clear by the manner in which she got their attention that something was very wrong.

43. Both officers ran to Ms Fu's cell. Officer A looked through the observation hatch and immediately radioed a 'code blue' medical emergency, indicating a life threatening incident. The communications room logged the call at 8.41am. She opened the door and supported Ms Fu as Officer B cut the ligature. They lowered Ms Fu onto her bed, with the help of another officer, who started cardiopulmonary resuscitation (CPR) around 8.44am. Officer A confirmed over her radio that an ambulance was required.
44. Both officers left Ms Fu's cell as other staff responded, including two nurses. Ms Fu was taken out of her cell and placed on the landing where there was more space. A short while later a nurse and a prison doctor, who had also responded to the code blue, arrived while CPR was in progress. Ms Fu was already outside her cell and the doctor told the investigator there were several rounds of CPR, and each time the automatic external defibrillator (AED) indicated there was no shockable heart rhythm.
45. An officer recorded that he requested an ambulance at 8.42am. Yorkshire Ambulance Service records state that they received the request for an ambulance at 8.49am. The doctor and the nurses present recorded Ms Fu had died at 8.54am (although paramedics were advised en route to New Hall that death was declared at 8.53am). Paramedics arrived at Ms Fu's cell at 9.02am. After they examined Ms Fu, they recorded at 9.22am that she was dead.
46. When paramedics left New Hall, they completed a 'service to service' information form. They recorded that they felt the handover from nursing staff and the doctor was poor as they were not given clear information on arrival. The doctor told paramedics that Ms Fu had an unshockable rhythm throughout, and had vomited. Paramedics said they felt they were initially prevented from examining Ms Fu and had concerns that CPR had not been undertaken as described: the defibrillator was not at the scene and there were no obvious signs of vomit in Ms Fu's airway. New Hall said the AED was taken to the scene, was used and remained on scene throughout. During resuscitation Ms Fu's airway was cleared of vomit and a second clear airway inserted.
47. A nurse made an entry in Ms Fu's medical record at 10.44am, recording who attended the emergency response and that CPR was carried out for 12 minutes between 8.42am and 8.54am. The doctor did not make an entry on the medical record, but made a statement that Ms Fu was pronounced dead at 8.54am.

### **Contact with Ms Fu's family**

48. The prison appointed a prison family liaison officer. The family liaison officer, a prison governor and a prison chaplain visited the family home to break the news

of her death and offered support to Ms Fu's family. The prison contributed towards the cost of the funeral in line with national instructions.

### **Support for prisoners and staff**

49. The Governor and her deputy debriefed the prison and healthcare staff involved in the emergency response and offered their support and that of the staff care team.
50. The prison posted notices informing prisoners of Ms Fu's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Ms Fu's death.

### **Post-mortem report**

51. A pathologist concluded that Ms Fu died from hanging. No illegal drugs or alcohol were detected.

# Findings

## Assessment of risk of suicide and self-harm

52. PSI 07/2015, *Early Days in Custody*, states that it is a mandatory requirement for staff to manage prisoners who arrive with an indication that they might be at risk of suicide and self-harm appropriately. PSI 07/2015, requires that the PER and any other available documentation must be examined in reception to assess the risk of self-harm or harm to others by the prisoner, or harm from others and states: *'The completed Person Escort Record (PER) form that must accompany each new prisoner, and any other available documentation, must be examined in Reception to identify any immediate needs and risks already recorded. Staff should also be aware that in cases where a prisoner has been remanded by the Courts, there will be a requirement to examine the PER for any indication of a risk to witnesses/victims ... The prisoner must also be interviewed, in private if possible, to discover and record any further immediate needs and risks, and any other information about the prisoner that may be relevant, particularly during their first night in custody.'*
53. Reception staff did not properly consider the information on Ms Fu's PER, or the information from her time in police custody, and the prison did not, therefore, comply with this instruction. PSI 64/2011 - *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, states that, after speaking to a prisoner, staff should use their judgement in combination with all available evidence to inform their decision as to whether a prisoner poses a risk to herself. Both instructions list a number of risk factors and triggers that might increase prisoners' risk of suicide and self-harm.
54. When she arrived at New Hall on 9 October, a number of these factors were relevant to Ms Fu: it was her first time in custody, she was a primary carer and had allegedly committed an offence against her young son, she had threatened to harm herself before she was arrested and had relationship problems. In addition, although Ms Fu was a British national, she had a very basic understanding of English. Although we do not know whether this would have affected the outcome for Ms Fu, there is little evidence these risk factors were fully considered.
55. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in April 2014, we identified that too often reception assessments place too much weight on staff's perception of the prisoner and they do not consider all relevant information. We reinforced these messages in a learning lessons bulletin, issued in February 2016, about early days and weeks in custody. None of the staff who had contact with Ms Fu during her time at New Hall considered her to be at risk of suicide because she appeared okay. A prisoner's presentation can reveal something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.

56. New Hall has introduced a new reception process since Ms Fu's death. Before a prisoner is located to a residential wing, prison and healthcare staff are now required to complete a 'First Night Immediate Risk and Need Assessment' document, which is copied to Safer Custody and the operational manager. While we welcome this review of the reception process, there is a need to ensure staff are fully aware of where information is held, have access to documentation arriving with a prisoner and are familiar with the potential risk factors and triggers outlined in the PSIs. We make the following recommendation:

**The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. First night procedures should recognise the additional vulnerabilities of newly arrived prisoners. In particular, this should ensure that reception, healthcare, first night staff and all others who assess risk:**

- **Have a clear understanding of their responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from Person Escort Record forms (PER) and other sources.**
- **Document the information considered and the decision whether or not to open an ACCT.**
- **Open an ACCT whenever a prisoner has significant risk factors, irrespective of their stated intentions.**

#### *Reception and Person Escort Records (PER)*

57. PER documents completed for Ms Fu's court appearances on 10 and 12 October were inaccurate and did not contain information from the original PER dated 9 October, which recorded her risk of suicide and self-harm, as well as a food allergy and that she was depressed. The investigator was told during interviews and anecdotally that the processes in reception were disjointed and information was not always shared or made available.
58. The Head of Operations told the investigator that a new system had been implemented to ensure all PER forms are checked by a residential manager and checked against information contained on previous documents to ensure all information relating to risk is captured. She also told the investigator that she is reviewing the nursing rota to establish if a change in shift patterns would increase the capacity of nursing staff in reception and provide better mental health nursing capacity. While we welcome the response from New Hall to the investigator's initial feedback, we nevertheless make the following recommendation:

**The Governor and Head of Healthcare should review the reception process, to ensure all documentation is available to inform assessment of risk.**

## Clinical care

59. Overall the clinical reviewer found that the care received by Ms Fu was not equivalent to the care she could have expected to receive in the community.

### *Initial healthscreen*

60. PSI 07/2015 outlines mandatory actions for healthcare staff. Annex D states: *'Prisoners who are about to spend their first night in prison custody must undergo a detailed medical examination before lock-up to assess their physical and mental health, including safer custody concerns'*. Further, NICE Guidance – Physical health of people in prison (NG57 November 2016 1.1) and Prison Service Order (PSO) 3050 – *Continuity of Healthcare for Prisoners*, Chapter 6 are clear that: *'For those prisoners passing through reception, prisons must have protocols in place for screening them for any potential healthcare, or suicide/self-harm issues.'*
61. None of the nurses who had contact with Ms Fu either in reception, or when she arrived on the wing, used an interpreter and did not establish if she had any ongoing medical conditions or prescribed medication. However, staff did not need to speak to Ms Fu to establish that she had a number of risk factors for suicide and self-harm, which had been recorded by the police in documents that arrived at New Hall with her. She attended court on two further occasions on 10 October and 12 October, yet nobody from healthcare assessed her.
62. While in reception on 9 October, Ms Fu gave a urine sample, which was abnormal and indicated she tested positive for ketones. While this could be an indicator that she had not eaten for a while, it is also an indicator of diabetes. There is no evidence that Ms Fu was diabetic, but healthcare staff did not know this and did not follow up to check. In other situations, this could be crucial to ensuring the health of a prisoner. The investigator was told that reception staff would typically only be looking for evidence of illicit substances and signs of withdrawal from drugs or alcohol.
63. A nurse started a first night care plan, which required Ms Fu to be checked hourly throughout the night. This is standard practice for all new prisoners. She made one entry on Ms Fu's medical record at 6.25am, to say she had slept all night, but did not record each separate check. The Head of Healthcare confirmed that the expectation would be that all checks were documented at the time, and not recorded retrospectively. She provided evidence to the investigator that since Ms Fu's death nursing staff have been required to undertake documentation training.

### *Continuity of healthcare*

64. The post-mortem report noted that Ms Fu was prescribed medication in the community for an overactive bladder (mirabegron & tolterodine), pain relief (mefanamic acid) and an antidepressant (mirtazapine), none of which were detected by toxicology tests as having been used prior to her death. PSO 3050 - *Continuity of Healthcare for Prisoners*, Chapter 2, states that efforts should be made to retrieve any information required from the prisoner's GP or other relevant service she has recently been in contact with. Because there was no

healthscreen, this did not happen. We therefore make the following recommendation:

**The Head of Healthcare should ensure that:**

- **All new receptions have an initial healthscreen and those returning from court, or any other outside appointment, are reassessed to identify if their needs or risk has changed.**
- **All abnormal urine analysis results are promptly followed up by a nurse or doctor.**
- **Observations are recorded contemporaneously.**
- **Every effort is made to obtain community medical records in line with PSO 3050.**

### Emergency response

65. New Hall's local protocol is clear that an ambulance should be called immediately, when a medical emergency code is radioed, in line with PSI 03/2013 – *Medical Emergency Response*. Officer A correctly radioed an emergency medical code at 8.41am, but an ambulance was not requested by the control room until 8.49am, eight minutes after Ms Fu was discovered. The investigator listened to a recording of the radio exchange. The officer in the control room responded to the radio message and instructed prison staff and nurses to attend. However, he did not immediately request an ambulance, but instead checked that one was required.
66. In a previous death at New Hall in June 2016, there was also a delay in requesting an ambulance when a code blue was called. Despite accepting our recommendation, the same issue has been identified. Since Ms Fu's death, the Head of Residence & Safety re-issued a notice to staff (232-17) on 21 November 2017, reminding control room staff they must immediately request an ambulance. All staff have been issued with an E.R.I.C card (emergency response in custody) which gives clear details of the medical emergency process and further training is planned to ensure all staff know the correct procedure to follow. As the prison has already taken steps to address this issue, we do not make a recommendation.

### Resuscitation

67. Officer B, who discovered Ms Fu, described her as 'floppy' and although she was not cold, she was not warm. A nurse said when she assessed Ms Fu, there were no signs of life, that she was cold, her pupils appeared fixed and her jaw was 'tight' when inserting an airway. She said that during resuscitation, because of the downward pressure, vomit came out of Ms Fu's mouth and a suction machine was used to clear her airway.
68. A prison doctor and a nurse stopped CPR after 12 minutes and declared Ms Fu had died. They told the investigator this was a joint decision, although the doctor said she did not know for certain if she was qualified to pronounce death and told the investigator, 'I'm assuming as a doctor that we are qualified'. She did not check Ms Fu's pupils and did not check for a pulse, but told the investigator the nurse had done these checks. The nurse confirmed that she completed these

checks, but assumed the doctor had also made these clinical checks. The doctor provided a one-line statement for the police confirming the date and time Ms Fu died, but did not make an entry on Ms Fu's medical record. She said she had relied on the nurse to make a full entry.

69. The clinical reviewer concluded that, in line with the Resuscitation Council Guidelines 2015, CPR should have continued until paramedics arrived.

**The Head of Healthcare should ensure all staff are given training and provided with clarification around CPR: when to stop and when it is appropriate to declare life extinct. A contemporaneous entry should be made on the medical record by all those directly involved.**

### *Medical handover to paramedics*

70. Paramedics completed a Datix incident report when they left New Hall (a computerised system to capture any adverse incident which has the potential to produce unexpected or unwanted effects, or any incident which has a consequence or a learning point). Paramedics recorded they were not given clear information on when Ms Fu had last been seen alive, when she had been found or the circumstances. They recorded that the prison doctor walked away from C Wing and the nurses present had to go away and confirm the details of when Ms Fu had been pronounced dead. The doctor told the investigator there were lots of people at the scene, she checked with her nursing colleagues and left as she did not think she was 'adding to anything by being there' and that the nurse was more experienced in a prison setting.
71. The investigator asked for information from the automatic external defibrillator (AED) to determine when and how long it had been used. New Hall were not able to provide the data as the AED model used was obsolete and they did not have the part which enabled this information to be retrieved.

**The Head of Healthcare should ensure that trained healthcare staff take control of resuscitation as soon as possible and provide a clear handover to attending paramedics.**

### **Interpretation services**

72. New Hall has a contract with a professional telephone interpreting service. PSI 64/2011 states: '*All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and/or during the risk management process.*'
73. The Prison Service's policy on foreign national prisoners states: '*Language barriers obviously make all other problems worse. Staff should not assume that prisoners with some comprehension of English have completely understood what is being said to them. Poor communication between staff and prisoners may have implications for things like risk of self-harm and good order and discipline.*'
74. Although Ms Fu was not a foreign national, information was not available to her in her first language. The SO correctly used Language Line in order to complete the reception interview, but healthcare staff did not use the service. A nurse told

the investigator that she did not have time to complete Ms Fu's healthscreen before the end of her shift at 7.30pm, and another nurse said she was unable to assess Ms Fu once she had arrived on C Wing as she was the only nurse. Other staff who met Ms Fu did not consider using Language Line and assumed Ms Fu understood them.

75. Prisoners on C Wing told the investigator Ms Fu was very quiet and largely stayed in her cell when not at court. This isolated her from others on the wing and cannot have helped her mental health. We make the following recommendation:

**The Governor, Head of Healthcare and Head of Chaplaincy should ensure that accredited interpreting services are used by all members of staff when interviewing or assessing prisoners who do not understand English well.**

### Morning wellbeing check

76. PSI 75/2011 - *Residential Services* states that: *'[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example by obtaining a response during the unlock process.'*
77. A roll check was completed at 6.10am, to check all prisoners were present in their cells, but this is not a welfare check. Two prisoners discovered Ms Fu at 8.40am while collecting laundry. She had not been unlocked at that time and therefore no member of staff had carried out a welfare check since she was locked up the previous evening, at around 10pm.
78. We were told that only those prisoners who require medication on the first night centre are unlocked between 7.00am and 8.00am, and those prisoners who are not required to attend work or other appointments are typically unlocked around 9.30am. The Head of Residence told the investigator that the regime on the first night centre could be a little different because of the need to complete induction, but that there was no current requirement to complete a wellbeing check on those prisoners who are not expected to leave their cell before 9.30am. As this could mean prisoners in the first few days of custody could go for a significant period of time without any interaction with staff to establish their wellbeing, we make the following recommendation:

**The Governor should ensure all prisoners are checked on the first night centre when unlock starts.**

### Chaplaincy

79. PSI 51/2011 - *Faith and Pastoral Care for Prisoners*, Chapter 2 states: *A Chaplain must see each new reception on an individual basis as soon as possible after they are received into the establishment. This may be a brief introductory visit and may be supplemented by an additional introductory session within a group setting. The initial individual visit should take place within 24 hours of the prisoner being received into the prison. PSI 51/2011 further states;*

*Visits to new receptions must be recorded in: Chaplaincy Team Journal, ACCT document (if relevant) and Prison-NOMIS case notes for any significant conversations.*

80. A prison chaplain met Ms Fu on Wednesday 11 October at around 9.30am as she was duty chaplain and required to see all new prisoners. (Chaplaincy was unable to see Ms Fu the previous day as she was attending court.) The chaplain did not make an entry in Ms Fu's prison record herself, and the record was made by her colleague later the same day. The chaplain said it was standard practice for the duty 'desk chaplain' to complete administration tasks, including making entries on a prisoner's record, rather than the person who actually had the contact. She said despite Ms Fu not understanding English, she did not consider using Language Line.
81. Making entries in a prisoner's record on behalf of someone else is poor practice and vital information about a person's presentation could be missed. We make the following recommendation:

**The Governor and Head of Chaplaincy should ensure all chaplaincy staff record their own contacts as soon as practicable.**

### **Cell Bell Records**

82. The investigator was unable to verify other prisoners' accounts that Ms Fu rang her cell bell several times during the night of 12 October. The system which records the operation of cell bells was not working effectively.
83. The site manager confirmed the cell bell data logging system records all pressed cell bells, logging the time, date and response time. He told the investigator the data logger was, as far as he was aware, in full working order and had not been reported faulty, via Planet FM (the maintenance contractor for repairs), prior to Ms Fu's death.
84. The site manager said he was asked to check the cell bell data logging system on 16 October and, by chance, there was an engineer and electrician at New Hall. He reported that when the engineer opened the door to the data logger cabinet, it had a portable heater, bags and other items stuffed inside which were covered in dust; this indicated the system had not been used for some time. He said when the system is not used for any length of time it will go into 'sleep mode' and will need rebooting in order to record cell bells. Engineers cleared out the items and rebooted the system so it was fully operational.

**The Governor should ensure that the system to record cell bells is fully operational at all times. When there is a fault, this should be reported immediately, via the appropriate reporting system, to ensure there is no delay in fixing faults.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations